| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
| *Company Tracking Number:* | *(FID)(2/09)(LG-P)* | | |
| *TOI:* | *H16G Group Health - Major Medical* | *Sub-TOI:* | *H16G.002A Large Group Only - PPO* |
| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

## Filing at a Glance

Company: Fidelity Life Association, a Legal Reserve Life Insurance Company

| | | |
|---|---|---|
| Product Name: Fidelity Life - Large Group (FID)(2/09)(LG-P) | SERFF Tr Num: ICCI-126261636 | State: Arkansas |
| TOI: H16G Group Health - Major Medical | SERFF Status: Closed-Approved-Closed | State Tr Num: 43256 |
| Sub-TOI: H16G.002A Large Group Only - PPO | Co Tr Num: (FID)(2/09)(LG-P) | State Status: Approved-Closed |
| Filing Type: Form | | Reviewer(s): Rosalind Minor |
| | Author: Brenda Dawson | Disposition Date: 09/01/2009 |
| | Date Submitted: 08/18/2009 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: Fidelity Life - Large Group (FID)(2/09)(LG-P) | Status of Filing in Domicile: |
| Project Number: Fidelity Life - Large Group (FID)(2/09)(LG-P) | Date Approved in Domicile: |
| Requested Filing Mode: | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Large |
| Overall Rate Impact: | Group Market Type: Employer |
| Filing Status Changed: 09/01/2009 | Explanation for Other Group Market Type: |
| | State Status Changed: 09/01/2009 |
| Deemer Date: | Created By: Brenda Dawson |
| Submitted By: Brenda Dawson | Corresponding Filing Tracking Number: |

Filing Description:

see attached cover letter and forms.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Brenda Dawson, Authorized Representative | Brendadawson@inscompliance.com |
| 3925 East State Street, Suite 200 | 815-316-6714 [Phone] |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

Rockford, IL 61108 815-986-2355 [FAX]

**Filing Company Information**

(This filing was made by a third party - insurancecomplianceconsultantsinc)

| | | |
|---|---|---|
| Fidelity Life Association, a Legal Reserve Life Insurance Company | CoCode: 63290 | State of Domicile: Illinois |
| P. O. Box 9269 | Group Code: | Company Type: |
| 1211 West 22nd Street | Group Name: | State ID Number: |
| Suite 209 | FEIN Number: 36-1068685 | |
| Oak Brook, IL 60522-9269 | | |
| (630) 522-0392 ext. [Phone] | | |

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# Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Fidelity Life Association, a Legal Reserve Life Insurance Company | $50.00 | 08/18/2009 | 29916879 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 09/01/2009 | 09/01/2009 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 08/28/2009 | 08/28/2009 | Brenda Dawson | 08/28/2009 | 08/28/2009 |

## Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Form | Schedule of Benefits | Ann Collins | 08/24/2009 | 08/24/2009 |
| Form | Amendatory Endorsement | Ann Collins | 08/24/2009 | 08/24/2009 |

### Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Certification for 25% benefit differential | Note To Reviewer | Brenda Dawson | 09/01/2009 | 09/01/2009 |
| PPP & Non-PPO Benefits | Note To Filer | Rosalind Minor | 09/01/2009 | 09/01/2009 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Disposition

Disposition Date: 09/01/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document *(revised)*** | Cover letter | Approved-Closed | Yes |
| **Supporting Document** | Cover letter | Replaced | Yes |
| **Supporting Document** | Authorization Letter | Approved-Closed | Yes |
| **Form** | Large Group Major Medical Policy | Approved-Closed | Yes |
| **Form** | Certificate | Approved-Closed | Yes |
| **Form *(revised)*** | Schedule of Benefits | Approved-Closed | Yes |
| **Form** | Schedule of Benefits | Replaced | Yes |
| **Form *(revised)*** | Amendatory Endorsement | Approved-Closed | Yes |
| **Form** | Amendatory Endorsement | Replaced | Yes |
| **Form** | Employer Application | Approved-Closed | Yes |
| **Form** | Employee Application | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 08/28/2009 |
| Submitted Date | 08/28/2009 |
| Respond By Date | |

Dear Brenda Dawson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Cover letter (Supporting Document)

Comment:
Your letter states that the endorsement will be attached to all certificates in Alabama. Please acknowledge that his should be in Arkansas.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 08/28/2009 |
| Submitted Date | 08/28/2009 |

Dear Rosalind Minor,

**Comments:**
Hi Rosalind and thank you for your letter.

## Response 1

Comments: The cover letter was revised to say that the Endorsement will be attached to all certificates issued in Arkansas.

**Related Objection 1**

Applies To:

- Cover letter (Supporting Document)

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
| *Company Tracking Number:* | *(FID)(2/09)(LG-P)* | | |
| *TOI:* | *H16G Group Health - Major Medical* | *Sub-TOI:* | *H16G.002A Large Group Only - PPO* |
| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

Comment:

Your letter states that the endorsement will be attached to all certificates in Alabama. Please acknowledge that his should be in Arkansas.

**Changed Items:**

**Supporting Document Schedule Item Changes**

Satisfied -Name: Cover letter

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I apologize for any inconvenience. Thank you.

Sincerely,
Brenda Dawson

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

**Note To Reviewer**

**Created By:**

Brenda Dawson on 09/01/2009 02:17 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

09/01/2009 03:09 PM

**Subject:**

Certification for 25% benefit differential

**Comments:**

This letter will certify that the In-network and out-of-network benefit levels comply with Bulletin 9-85 and that there will never be more than a 25% differential between In-network and out-of-network providers.

Thank you.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
| *Company Tracking Number:* | *(FID)(2/09)(LG-P)* | | |
| *TOI:* | *H16G Group Health - Major Medical* | *Sub-TOI:* | *H16G.002A Large Group Only - PPO* |
| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

**Note To Filer**

**Created By:**
Rosalind Minor on 09/01/2009 02:07 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
09/01/2009 03:09 PM
**Subject:**
PPP & Non-PPO Benefits
**Comments:**

Before approval is given to this submission, please certify that the benefits payable a PPO & Non-PPO will comply with our Bulletin 9-85 which states in part that there should be no more than a 25% differential in payment between a PPO & Non-PPO.

Thank you for your cooperation in this matter.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

**Amendment Letter**

Submitted Date: 08/24/2009

**Comments:**

Please find attached a revised amendatory endorsement and a revised schedule of benefits.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number | Form Type | Form Name | Action | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| (FID)(2/09)(LG-S) AR | Schedule Pages | Schedule of Benefits | Initial | | | | | AR (FID)(2-09)(LG-S) AR Schedule of Benefits 8-24-09 clean copy.pdf |
| (FID)(AEAR)(2/09) | Certificate Amendment, Insert Page, Endorsement or Rider | Amendatory Endorsement | Initial | | | | | (FID)(AEAR)(2-09) 8-24-09 clean copy.pdf |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
| *Company Tracking Number:* | *(FID)(2/09)(LG-P)* | | |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Form Schedule

**Lead Form Number: (FID)(2/09)(LG-P)**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 09/01/2009 | (FID)(2/09)(LG-P) | Policy/Contract/Fraternal Certificate | Large Group Major Medical Policy | Initial | | | FID (10-08) (LG-P) 5-19-09.pdf |
| Approved-Closed 09/01/2009 | (FID)(2/09)(LG-C) | Certificate | Certificate | Initial | | | FID 2-09 - LG -6-24-09.pdf |
| Approved-Closed 09/01/2009 | (FID)(2/09)(LG-S) AR | Schedule Pages | Schedule of Benefits | Initial | | | AR (FID)(2-09)(LG-S) AR Schedule of Benefits 8-24-09 clean copy.pdf |
| Approved-Closed 09/01/2009 | (FID)(AEAR)(2/09) | Certificate Amendment, Insert Page, Endorsement or Rider | Amendatory Endorsement | Initial | | | (FID)(AEAR)(2-09) 8-24-09 clean copy.pdf |
| Approved-Closed 09/01/2009 | (FID)(2/09)(LG-ER) AR | Application/Enrollment Form | Employer Application | Initial | | | AR FID 10-08 LG-ER 2-10-09.pdf |
| Approved-Closed 09/01/2009 | (FID)(2/09)(LG-EE) AR | Application/Enrollment Form | Employee Application | Initial | | | AR FID 10-08 LG-EE 2-10-09.pdf |

**FIDELITY LIFE ASSOCIATION, a Legal Reserve Life Insurance Company**
[1211 West 22nd Street, Suite 209, Oak Brook, IL 60523]

**GROUP POLICY NUMBER: [XXXXXX]**

**POLICYHOLDER**: [XYZ Company]

**DATE OF ISSUE**: [December 1, 2008]

**RENEWAL PREMIUMS ARE DUE MONTHLY** beginning on the [1st day of January, 2009] and on the 1st day of each month thereafter, in United States Dollars only.

**POLICY ANNIVERSARIES** occur annually beginning [January, 2009]

**STATE OF DELIVERY**: [XXXX]

Fidelity Life Association, a Legal Reserve Life Insurance Company (hereinafter referred to as the Insurance Company, We, Our, or Us) agrees to pay the Group Insurance Benefits herein provided to each insured Employee of a Policyholder, subject to the terms and conditions of the Policy. Benefits are payable in United States Dollars only.

The Policy is issued to the Policyholder in consideration of application and payment of premiums, to take effect as of the Date of Issue. The Policy will terminate as hereinafter provided.

All periods indicated herein begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

The first premium is due on the Date of Issue and renewal premiums are due monthly during the continuance of the Policy.

The Policy is delivered in and is governed by the laws of the state of delivery.

The benefits and provisions set forth on the following pages and riders are a part of the Policy as if recited over the parties' signatures.

IN WITNESS WHEREOF, the Insurance Company has caused the Policy to be executed at its Home Office in City, State.

[ ][ ]

Secretary President

**TABLE OF CONTENTS**

**1. SCHEDULE OF BENEFITS:**

The attached Certificate of Group Insurance is incorporated into and made a part of this Policy.

The Policyholder/Employer/Plan Administrator (hereinafter referred to as "Employer") selected the following insurance benefits which are described in the attached Certificate of Group Insurance:

MAJOR MEDICAL EXPENSE INSURANCE

The insurance benefits and coverage are as selected and agreed upon between Us and the Employer. All coverages and actual benefit amounts in effect with respect to each insured Employee and his insured Dependents, if any, will be as described in the individual Certificate issued by Us to or for that Employee which will include his or her personal Schedule of Benefits.

**2. DEFINITIONS**

All terms are as defined in the attached Certificate of Insurance.

**3. THE CONTRACT**

The Policy, the application of the Employer, the Certificate and the Employees' applications, if any, shall constitute the entire contract between the parties. All statements made by the Employer or by the Employees shall be deemed representations and not warranties. No such statement, in the absence of fraud, shall be used in any contest under the Policy unless it is contained in a written instrument and a copy of the instrument is or has been furnished to the Employer or Employee.

**4. INCONTESTABILITY**

The validity of the Policy shall not be contested, except for non-payment of premiums by the Employer, after it has been in force for two years from its date of issue. No statement made by the Employer or any Employee, except a fraudulent misstatement, shall be used to contest the validity of any insurance with respect to which that statement was made after the insurance has been in force for two years prior to the contest and is contained in a written instrument signed by the Employee, and a copy of such instrument is or has been furnished to him or to his Employer.

**5. INDIVIDUAL CERTIFICATES**

We will issue to each Employer for delivery to each Employee, an individual certificate which states the essential features of the insurance to which the Employee is entitled, to whom benefits are payable, each limitation or requirement in the Policy that pertains to the Employee, and the requirements for payment of benefits.

**6. POLICYHOLDER NOT INSURANCE COMPANY'S AGENT**

The Employer shall not be considered the Insurance Company's agent for any purpose under the Policy.

**7. ELIGIBILITY FOR INSURANCE**

An Employee and/or his Dependents will be eligible for insurance as provided in Part 2 – ELIGIBILITY FOR INSURANCE in the Certificate of Group Insurance.

**8. EFFECTIVE DATE OF INSURANCE**

Insurance for an Employee and/or his Dependents shall be effective as provided in Part 3 - EFFECTIVE DATE OF INSURANCE in the Certificate of Group Insurance.

**9. TERMINATION OF INSURANCE**

Insurance for an Employer, Employee and/or his Dependents shall terminate as provided in Part 10 – RENEWABILITY AND TERMINATION in the Certificate of Group Insurance.

**10. RENEWABILITY OF INSURANCE**

The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of or by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's residence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer

the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state.

9. We decide to discontinue offering all health insurance in the large group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the large group market in the state of the Employer's residence and will not renew coverage in the state of the Employer's reisidence.

All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

**11. PREMIUMS**

Payment Of Premium

Premiums are payable by the Employer to Us in accordance with Our then current premium rating manual. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

1. We reserve the right to change the rates on any premium due by giving written notice to the Policyholder at least thirty (30) days in advance of the change.
2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves refund of unearned premium shall be limited to the three (3) months immediately preceding the date that We determine the adjustment in premium should be made and We will reduce that refund by the amount of benefits paid for claims incurred during the period for which the refund is made.
3. Premium due dates are the first of a calendar month. All insurance shall be charged from and to the premium due date.

Grace Period. The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

**12. NON PARTICIPATING**

The Policy does not share in the surplus earnings of the Insurance Company and no refund or assessment shall be made to the Employer or Employee of any excess or deficit earnings of the Insurance Company.

**13. MISSTATEMENT OF AGE**

If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

**14. CONFORMITY WITH LAW**

If any provision of the Policy is contrary to federal or state law, this Policy is hereby amended to conform thereto.

**15. EMPLOYEE PARTICIPATION AND CONTRIBUTION REQUIREMENTS**

The following Employee Participation and Contribution Requirements must be met and maintained at all times. Employees: Participation by a minimum of 2 Eligible Employees is required at all times, and 75% Employee participation is required at all times. No more than 50% of the total number of eligible Employees may waive insurance under the Policy by reason of having other Creditable Coverage.

If for any reason the Employer falls below any or all of the minimum number participation or minimum percentage participation requirements, the Employer has a 6 month period, beginning on the premium due date that coincides with or next follows the date the event occurs, to reestablish and continue the minimum participation requirement(s). If the minimum participation requirement(s) is (are) not continued for at least 6 consecutive months, and not

reestablished by the end of that 6 month period, all insurance under the Policy for the Employer and its Employees shall terminate.

For coverage for Eligible Employees to become and remain effective, an Eligible Employee must contribute at least 25% of the monthly premium due for Employee only insurance under the Policy.

**16. EMPLOYER RESPONSIBILITIES**

The Employer agrees:

1. To offer each employee the opportunity to elect group coverage under The Policy when he or she attains the status of an Employee as provided for in The Policy. It is understood that Employees are free to choose either Our Group Coverage or any other such group coverage as may be made available by the Employer. Every Employee will be given a fair opportunity to elect one of such options over the other and will not be penalized by the Employer because of such a choice.
2. To furnish Us on a monthly basis on Our-approved forms, such information as may reasonably be required by Us for the administration of the group coverage, including any change in a Insured Person's eligibility status.
3. To comply with all policies and procedures established by Us in administering and interpreting the group coverage.
4. To furnish all enrollment and termination change notifications to Us solely on Our enrollment and termination forms and within the time periods required by The Policy.
5. At reasonable times while the group coverage is in force, and for 24 months after that, We may inspect any of the Employer's documents, books, or records that may affect the claims arising from The Policy or its premiums.

**17. CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA)**

If an Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (COBRA), The Policy will provide its group heath coverage as required by COBRA's laws and regulations.

We will allow COBRA continuation, however, only if:

1. A COBRA election form is signed by the qualified beneficiary within the time frames prescribed by COBRA; and
2. The Employer notifies Us in writing, of the qualified beneficiary's request to continue coverage within 31 days from the date the qualified beneficiary signed the COBRA election form.

   Any continued coverage allowed under this provision will provide only the minimum benefits for the minimum length of time as required by COBRA on the date a person covered by The Policy becomes a qualified beneficiary.

   We assume no liability for any damages resulting from an Employer's non-compliance with any COBRA requirement or regulation. Additionally, an Employer will hold Us harmless and indemnify Us against any and all taxes, fines, penalties, losses, damages, costs, expenses, and legal fees incurred by Us, except to the extent prohibited by law, for any failure on the part of the Employer to comply with COBRA requirements or its regulations.

**FIDELITY LIFE ASSOCIATION,** a Legal Reserve Life Insurance Company

Oak Brook, Illinois

## EMPLOYER GROUP INSURANCE

## CERTIFICATE OF GROUP INSURANCE

This individual Certificate is issued as evidence of the insurance provided under the Group Policy (the Policy), issued to the above Policyholder.

The insurance described herein is effective only if the individual is eligible for such insurance, premiums are paid to the Insurance Company on account of such individual and the individual becomes and remains insured as provided in the Policy. The provisions described in this Certificate are subject to all the provisions, terms and conditions of the Policy. The Policy may be amended, changed, canceled or discontinued in accordance with the provisions thereof, without the consent of the individual. This Certificate supersedes and replaces any and all other insurance certificates and riders that may have been issued to the individual insured under any and all Group Policies issued to the Policyholder by:

**FIDELITY LIFE ASSOCIATION, a Legal Reserve Life Insurance Company**
(Herein referred to as the Insurance Company, We, Our or Us)

[ ][ ]

**SECRETARY** **PRESIDENT**

The provisions and benefits described herein may be different from any and all group insurance coverage You may have or have had. Please read this Certificate carefully.

**CERTIFICATE FACE PAGE**

Certificate Issued To: «Insured_Name»

Herein Called the Employee and to Insured Dependents:

| | |
|---|---|
| «Dependent_1» | «Dependent_2» |
| «Dependent_3» | «Dependent_4» |
| «Dependent_5» | «Dependent_6» |
| «Dependent_7» | «Dependent_8» |
| «Dependent_9» | «Dependent_10» |
| «Dependent_11» | «Dependent_12» |

Effective Date of Insured: «Insured_Effective_Date»

Policy Number: «Policy»

Policyholder, Employer and Plan Administrator: «The ABC Company»

Employer Effective Date: «Employer_Effective_Date»

COVERAGE ISSUED: «Coverages»

**NOTICE OF PRE-EXISTING CONDITION LIMITATION**

Coverage under the Policy is subject to a pre-existing condition limitation until the following date:

| Name | Date | Name | Date |
|---|---|---|---|
| «Insured_Name» | «InsuredPXT» | «Dependent_1» | «D1PXT» |
| «Dependent_2» | «D2PXT» | «Dependent_3» | «D3PXT» |
| «Dependent_4» | «D4PXT» | «Dependent_5» | «D5PXT» |
| «Dependent_6» | «D6PXT» | «Dependent_7» | «D7PXT» |
| «Dependent_8» | «D8PXT» | «Dependent_9» | «D9PXT» |
| «Dependent_10» | «D10PXT» | «Dependent_11» | «D11PXT» |
| «Dependent_12» | «D12PXT» | | |

If You believe that You and/or Your dependents should not be subject to a pre-existing condition limitation or that the pre-existing limitation should be for a shorter period of time, You and/or Your dependents may request a certificate from a prior plan or issuer that demonstrates prior creditable coverage.

**Certificate Index**

## PART 1 – DEFINITIONS

**ACCIDENT/ACCIDENTAL** means any sudden or unforeseen event which:

1. causes harm to the physical structure of the body;
2. results from an external agent or trauma;
3. is definite as to time and place; and
4. happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.

**ACUPUNCTURE** means the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician or licensed acupuncturist.

**AMBULANCE -** means a vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care. Air ambulance charges are payable only for transportation from the site of an Emergency to the nearest available Hospital that is equipped to treat the condition instead of local Ambulance service.

**AMBULATORY SURGICAL CENTER** means any public or private establishment: a) with an organized medical staff of Physicians; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Physician services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

**CALENDAR YEAR** if shown on the Schedule of Benefits means the period of time which begins on January 1st and ends on the following December 31st. When a person first becomes an Insured Person, the first Calendar Year begins on the Effective Date of coverage and ends the following December 31st.

**CERTIFICATE/CERTIFICATE OF INSURANCE** means the summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

**CHEMICAL DEPENDENCY** means the abuse of or psychological or physical dependency on or addiction to alcohol or a controlled substance.

**COINSURANCE/COINSURANCE PERCENTAGE** means the Insured Person's share of Covered Charges under the Policy after any applicable [Copays and] Deductibles are satisfied and before the Coinsurance Limit is reached. The Coinsurance Percentage is shown in the Schedule of Benefits.

**COINSURANCE LIMIT** means the maximum amount of Covered Charges an Insured Person will pay in a Year, after any applicable [Copays and the] Deductibles are satisfied and before the Maximum Benefit or other plan maximums are reached. The Coinsurance Limit is shown in the Schedule of Benefits. After the Coinsurance Limit is reached, We will pay the remainder of the Covered Charges incurred by that Insured Person during the rest of that Year.

A higher Coinsurance Limit, as shown in the Schedule, may apply when Out-of-Network Providers are utilized.

**COMPLICATIONS OF PREGNANCY** (which are considered to be a Sickness under the Policy) means: a) conditions requiring Inpatient treatment (when pregnancy is not terminated); b) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and c) non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth, as defined by the World Health Organization, is not possible. Complications of pregnancy does not include a scheduled cesarean section, complicated or difficult pregnancy with diagnoses such as false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, preeclampsia and other similar conditions associated with a difficult pregnancy.

**COPAY** means the amount required to be paid by an Insured Person each time a specific service is provided, as set forth in the Schedule of Benefits and the Policy. Copay amounts are deducted before any applicable Deductible or Benefit Percentage is applied. In some instances, more than one Copay may be required. Services requiring Copays and Copay amounts are shown in the Schedule of Benefits.

**COSMETIC SURGERY** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or self-esteem.

**COVERED CHARGES** means charges incurred as a result of an Injury or Sickness by or on behalf of an Insured Person while the Policy is in force with respect to such Insured Person and which:

1. are Medically Necessary for the treatment of an Injury or Sickness and which have been recommended and prescribed by a Physician;
2. are not in excess of Reasonable and Customary Charges, Fees and Expenses made for the services performed or supplies furnished, or are not in excess of such Charges as would have been made in the absence of this insurance;
3. are not excluded from coverage by the terms of the Policy; and
4. do not exceed any amounts payable under the terms of the Policy.

**CREDITABLE COVERAGE** means benefits or coverage provided under:

1. a group health plan;
2. health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C.A. Section 1395c or 1395j et seq.);
4. Title XIX of the Social Security Act (42 U.S.C.A. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 (42 U.S.C.A. Section 1396s);
5. Chapter 55 of Title 10 of the US Code;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a state health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5 of the US Code;
9. a public health plan as defined by federal regulations; or
10. a health benefit plan under Section 2504(e) of Title 22 of the US Code;

Creditable Coverage does not include:

1. Benefits not subject to requirements:
   - A. Coverage only for accident or disability income insurance or any combination thereof;
   - B. coverage issued as a supplement to liability insurance;
   - C. liability insurance, including general liability insurance and automobile liability insurance;
   - D. workers' compensation insurance or other similar insurance;
   - E. automobile medical payment insurance;
   - F. credit-only insurance;
   - G. coverage for on-site medical clinics;
   - H. other similar insurance specified by federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Benefits not subject to requirements if offered separately:
   - A. limited-scope dental or vision benefits;
   - B. benefits for long-term care, nursing home care, home health care, or community-based care coverage or any combination thereof;
   - C. such other similar limited benefits specified by federal regulations;

3. Benefits not subject to requirements if offered as independent, noncoordinated benefits:
   - A. coverage only for a specified disease or illness;
   - B. hospital indemnity or other fixed indemnity insurance.

4. Benefits not subject to requirements if offered as separate insurance policy:
   - A. Medicare supplemental health insurance, as defined by Section Section 1395ss(g)91) of the US Code),
   - B. coverage supplemental to the coverage provided under Chapter 55 of Title 10, and
   - C. other similar supplemental coverage provided under a group health plan.

**CUSTODIAL OR CONVALESCENCE CARE** means any care that is provided to an Insured Person who is disabled and needs help to support the essential activities of daily living when the Insured Person is not under active and specific

medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

**DEDUCTIBLE** means the amount of applicable Covered Charges [other than Copays], that must be incurred by an Insured Person in any Year before benefits will be payable under the Policy. A higher Deductible amount may apply when Out-of-Network Providers are utilized for non-Emergency care. The Deductible is shown in the Schedule of Benefits or on an amendment to this Certificate.

**DEPENDENT/ELIGIBLE DEPENDENT** means an Employee's:

1. lawful spouse;
2. unmarried child, unmarried adopted child, unmarried child placed in Your home for adoption and unmarried child in Your custody pursuant to court order who is primarily dependent upon the Employee for support and maintenance and is:
    a. under 19 years of age and living in Your home; or
    b. Between 19 and 23 years of age provided however, that the child is dependent upon the Employee for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, will be determined according to the standards of the accredited college or university being attended by the Dependent.

    Placed for adoption means in the physical custody of the adoptive parent.

If both husband and wife are Employees of the Employer, each person must apply as an Employee. If both husband and wife are covered as Employees, a child may be covered as the Dependent of either Employee, but not both.

**DURABLE MEDICAL EQUIPMENT** means equipment that is:

1. able to withstand repeated use;
2. primarily and customarily used to serve a medical purpose;
3. not generally useful to a person in the absence of Injury or Sickness; and
4. prescribed by a Physician and Medically Necessary.

**ELIGIBLE EMPLOYEE** means an Employee who works on a full-time basis at least 30 hours a week for the Employer. The term does not include an Employee who:

1. works on a part-time, temporary, seasonal, or substitute basis;
2. is covered under:
    A. another health benefit plan; or
    B. a self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
3. elects not to be covered under the Employer's health benefit plan and is covered under:
    A. the Medicaid program;
    B. another federal program, including the CHAMPUS program or Medicare program; or
    C. a benefit plan established in another country.

**EMERGENCY ADMISSION** means an admission of an Insured Person who experiences an Emergency Medical Condition resulting from an Injury or Sickness.

**EMERGENCY/MEDICALEMERGENCY** means the sudden and unexpected onset of one or more acute conditions calling for medical services which the Insured Person receives right after the onset of such condition(s) or as soon as possible after he/she experiences such condition(s). For example, such an emergency includes heart attack, cardiovascular accident, poisoning, loss of consciousness or loss of breathing. These and other conditions are medical emergencies when all of the following are met, as determined by Us:

1. The Insured Person requires immediate medical care;
2. The onset of severe symptom(s) of the acute condition(s) is sudden and unexpected. The symptom(s) must be severe enough to cause a reasonably prudent person to seek medical care right away, no matter what time of day it is;
3. Immediate medical care must be obtained (if it is not, it is not am medical emergency); and
4. A health care Provider’s diagnosis of the symptom(s) indicates the condition(s) required immediate medical care.

**EMPLOYEE** means an individual employed by an Employer.

**EMPLOYER** means in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. An Employer must complete an Employer Application agreeing to all the terms specified by Us and meet all other requirements in the state of the Employer's residence. The Employer is deemed the Plan Administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act ("ERISA") and Consolidated Omnibus Budget Reconciliation Act ("COBRA").

**EMPLOYER'S EFFECTIVE DATE** means the Effective Date of coverage for Your Employer.

**ENROLLMENT DATE** means the date an Employee or Dependent enrolls under the Policy or, if earlier, the first day of any Service Waiting Period that must be satisfied before coverage becomes effective.

**ENROLLMENT FORM** means the form designated by Us that an Employee must complete and submit in order to request enrollment in the Policy. Enrollment Forms are available from Your Employer and must be submitted to Your Employer to be forwarded to Us.

**EXPERIMENTAL** means a service for which one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings. We will determine if this item 2. is true based on:
   A. Published reports in authoritative medical literature; and
   B. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health and the FDA.
3. In the case of a drug, a device or other supply that is subject to FDA approval:
   A. It does not have FDA approval; or
   B. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
      1) included in substantially accepted peer-reviewed medical literature such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
      2) included in a prescription drug reference compendium; or
      3) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5 applies for protocols used by the Insured Person's Provider as well as for protocols used by other Providers studying substantially the same service or supply.

**GEOGRAPHIC AREA** means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided, or a greater area if necessary, to obtain a representative cross-section of charges for a like treatment, service, procedure, device, drug or supply.

**HEALTH BENEFIT PLAN** means any Hospital or medical policy or certificate, Hospital or medical service plan contract, or health maintenance organization subscriber contract.

**HOME HEALTH CARE AGENCY** means a business that provides home health service under a Home Health Care Plan.

**HOME HEALTH CARE PLAN** means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Physician. An attending Physician must certify that proper treatment of the Bodily Injury or Sickness would require confinement in a Hospital or a Skilled Nursing Facility in the absence of the services and supplies provided as a part of a treatment plan for Home Health Care.

**HOSPICE** means a facility that:

1. is licensed, accredited or approved by the proper authority to provide a Hospice Care Program;
2. admits individuals who:

A. have no reasonable prospect of cure; and
B. have a life expectancy of six (6) months or less; and

3. provides care by a Hospice Team coordinating its services with the patient's attending Physician and the patient's Family.

**HOSPICE CARE PROGRAM** means a coordinated program for meeting the needs of dying individuals and their families by providing medical, nursing and other health services during the Sickness and bereavement.

**HOSPICE TEAM** means a group of persons composed of a Hospice Physician, a patient care coordinator (a Physician or licensed graduate registered nurse (RN)), a licensed graduate registered nurse (RN), a mental health specialist, a social worker, a Chaplain and a lay volunteer.

**HOSPITAL** means a facility which:

1. Is licensed as a hospital and operated pursuant to law:
2. Is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an Inpatient basis for which charge is made;
3. Provides 24 hour nursing care by or under the supervision of a registered nurse (R.N.);
4. Is an institution which maintains and operates a minimum of five beds;
5. Has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. Maintains permanent medical records.

The term "Hospital" includes a Chemical Dependency Treatment Center, but does not include:

1. Military or veteran's hospital or soldier's home or any hospital contracted for or operated by the federal government or any agency thereof for the treatment of members or ex-members of the armed forces;
2. Convalescent homes, convalescent facilities, rest facilities, or nursing facilities; or
3. Home or facilities primarily for the aged, those primarily affording custodial care or educational care.

**IMMEDIATE FAMILY** means (step) brothers, (step) sisters, (step) children, (step) parents, aunts, uncles and legal spouses.

**INITIAL ENROLLMENT PERIOD** means the period of time during which an Employee or Dependent is first eligible to enroll under the Policy.

**INJECTABLE AND SPECIALTY MEDICATION** means those covered drugs that are administered in an Insured Person's home intravenously, intramuscularly, or subcutaneously, or are used as immunosuppressant agents in organ transplant patients.

**INJURY** means physical harm or damage caused by an Accident. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity, or any other causes. Any loss due to Injury must begin while the Insured Person's coverage is in force.

**IN-NETWORK** means those Covered Charges received from a Preferred Provider.

**INPATIENT** means an Insured Person confined and assigned to a Hospital bed for a period of twenty-three (23) consecutive hours or longer upon the advice of a Physician for other than Custodial or Convalescent Care.

**INSURED PERSON/INSURED** means the Employee named in the Schedule of Benefits and any Covered Dependents whose coverage with Us is in effect and has not terminated.

**INTENSIVE CARE UNIT** means that part of a Hospital specifically designed as an Intensive Care Unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards. This care includes close observation by trained and qualified personnel primarily assigned to this part of the Hospital. This term shall not include Intermediate Care or Stepdown Units.

**LATE ENROLLEE** means an Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period when the Enrollment Form is submitted.

**LIFE-THREATENING** means a condition which, if not immediately interrupted by medical treatment, has a high likelihood of: (1) death, if the end point of the medical treatment is survival; or (2) causing major irreversible morbidity (including: loss of arm, leg, hand or foot; loss of sight or hearing; paralysis; or loss of brain function), if the end point of the medical treatment is survival and/or avoiding that morbidity. The attending Physician must verify the condition to be life-threatening.

**MEDICALLY NECESSARY** means services or supplies that are:

1. Required to identify or treat an Insured Person's diagnosis, symptoms, Sickness, Injury or disease;
2. In accordance with recognized standards of medical care as depicted by:
   A. use in the state where the Insured Person resides or use throughout the United States; or
   B. scientific or medical evidence accepted by a majority of the medical specialty involved.
3. Classified, recognized or acknowledged by a governmental agency as proven, safe, effective, and not Investigational, Experimental and/or for Research;
4. not in excess, in scope of duration or intensity, of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment;
5. Not solely for:
   A. the convenience of the Insured Person, the Insured Person's family, or Provider;
   B. educational purposes; and
   C. Investigational, Experimental and/or for Research, or cosmetic purposes.

**MEDICARE** means the Health Insurance for the Aged Act, Title XVIII, Social Security Amendments of 1965, as amended.

**MENTAL OR NERVOUS DISORDER** means any nervous, emotional and mental disease, illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or nervous disorder that may be a manifestation of an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Mental or Nervous Disorder does not include Serious Mental Illness.

**NEGOTIATED RATE** means the rate mutually agreed upon between Us and a Provider in a specific instance.

**OCCUPATIONAL THERAPY** means treatment of disease by physical agents and methods to assist in rehabilitation and restoration, of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, through a program designed to improve endurance, strength, exercise tolerance, and performance of activities of daily living (ADL), but only if such treatment results in measurable improvement and is provided by a Physician or licensed or registered occupational therapist (O.T.R.). Maintenance therapy or other treatment provided on a routine basis as part of a standard program, and educational training or services designed and adapted to develop a physical function, are not included.

**ORTHOPEDIC MANIPULATION** means treatment by a Physician for physical therapy or manipulation involving the spine or any joint to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after Injury or Sickness, but only if such treatment results in measurable improvement and is provided by a Physician. This includes traction; inversion therapy; hot or cold packs; electrical stimulation therapy; vasopneumatic devices; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; massage therapy; thermography; biofeedback therapy; hydrocollator therapy; passive motion therapy; acupressure; office visits and consultations.

**OUT-OF-NETWORK PROVIDER** means any Physician, Hospital or other health care Provider who is not a member of a PPO network contracted with Us to provide medical services to Our Insureds.

**OUTPATIENT EXPENSES** means Covered Charges incurred by an Insured Person that are not on an Inpatient basis.

**PHYSICIAN** means a person who has successfully completed the prescribed course of studies in medicine at an officially recognized medical school and has acquired the requisite qualifications for licensure in the practice of medicine. The person must be a legally qualified, licensed practitioner who provides care within the scope of his/her license, and who is not a member of the Insured Person's Immediate Family. An Insured Person will not be considered a Physician for care or treatment rendered to his/herself or his/her Immediate Family.

**PLAN YEAR** if shown on the Schedule of Benefits means the period of time which begins immediately on the Employer's Effective Date and ends each 12 months following the initial Effective Date. When a person first becomes an Insured Person, the first Plan Year begins on the Insured Person's Effective Date and ends on the next following Employer's anniversary date.

**POLICYHOLDER OR GROUP POLICYHOLDER** means the Employer identified as the Policyholder in the Schedule of Benefits.

**PRE-AUTHORIZATION** means a screening process using established medical criteria to determine whether the proposed treatment plan is appropriate. It may include proposing alternative treatment plans, concurrent length of stay reviews, and discharge planning.

**PRE-EXISTING CONDITION** means any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months immediately preceding the Enrollment Date; except that We will not treat genetic information or Pregnancy as a Pre-Existing Condition.

**PREFERRED PROVIDER/IN-NETWORK PROVIDER** means a Physician, Hospital or other health care Provider that is currently a member of a Preferred Provider Organization (PPO) network contracted with Us to provide medical services to Our Insureds. The PPO network is named on the ID card. We will provide access to a directory listing In-Network Preferred Providers. You should, however, always check to be sure a listed Provider is still a participating member of the PPO network at the time medical services are needed. A toll-free number is provided on Your ID card to locate Preferred Providers.

**PREGNANCY** means the period following the receipt by an Employee, Dependent spouse or Dependent child of a diagnosis of Pregnancy until the discharge of the Employee, Dependent spouse or Dependent child from the Hospital or other Facility following the delivery of the newborn child. Pregnancy does not include voluntary abortion except where the Employee, Dependent spouse or Dependent child has a Life-Threatening condition.

**PRESCRIPTION DRUG/PRESCRIPTION MEDICATION** means any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

**PROVIDER** means a Physician, Hospital, or any other duly licensed institution or duly licensed individual providing medical or health services.

**REASONABLE AND CUSTOMARY CHARGES** means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred, so long as those charges are reasonable. The "most common charge" means the lesser of:

1. the actual amount charged by the Provider;
2. the negotiated rate;
3. the charge which would have been made by the Provider (Physician, Hospital, etc.) in the absence of insurance;
4. the charge which would have been made by the Provider for a comparable service or supply; or
5. the charge by other Providers in the same Geographic Area, as reasonably determined by Us, for the same or comparable service or supply.

In determining whether a charge is reasonable, We may consider other factors, including but not limited to:

1. the complexity of service or supply involved;
2. the degree of professional skill, experience and training required for a Physician to perform the procedure or service;
3. the severity or nature of the Injury or Sickness being treated;
4. the Provider's adherence or failure to adhere to charging and practices generally accepted by an established United States medical society as determined by Us;
5. the cost to the Provider of providing the service or supplies, or performing the procedure; or
6. if the information above is not sufficient to determine whether a charge is reasonable for a Geographic Area, We may refer to National Data Bases reflecting Provider fee data.

**REHABILITATION FACILITY** means a legally operating institution or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, is

duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services.

**REHABILITATIVE SERVICES** means treatment, services and supplies for the purpose of restoring bodily function, which has been lost due to either an Injury or Sickness. Care ceases to be Rehabilitative Services when either (i) the Insured Person can perform the activities which are normal for the same age and gender; or (ii) the Insured Person has reached the maximum therapeutic benefit and further Rehabilitative Services cannot restore further bodily function beyond the level the Insured Person currently possesses.

**SERIOUS MENTAL ILLNESS** means schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); and obsessive compulsive disorders. Serious Mental Illness does not include Mental or Nervous Disorder.

**SERVICE WAITING PERIOD** means a period of time that must pass with respect to an Employee before the Employee is eligible to be covered for benefits under the terms of the Group Policy. The Service Waiting Period is determined by the Employer on its application for coverage under the Group Policy.

**SICKNESS** means an illness, disease, Pregnancy or Complications of Pregnancy that causes loss while an Insured Person's coverage is in force under the Policy.

**SKILLED NURSING FACILITY** means a place that meets all these requirements:

1. it operates within the law;
2. it provides for the care and treatment of persons recovering from an Injury or Sickness;
3. it provides room, board, and skilled nursing services;
4. it operates under the supervision of a Physician;
5. it has 24-hour nursing service which is under the supervision of a registered nurse (RN) who is on site at all times; and
6. it keeps a daily record of medical care provided to each patient.

It does not mean a rest home, a home for the aged, or a place operated primarily to provide Custodial Care.

**SOUND NATURAL TEETH** means teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

**TRANSPLANT NETWORK** means a health services organization, designated as a Transplant Network by the Company, which has entered into an agreement with, or on behalf of, the Company, to render Medically Necessary and medically appropriate specialty services. A Transplant Network may or may not be located within an Insured Person's Geographic Area. Services provided through a Transplant Network are coordinated by the Company.

**US, WE, OUR or COMPANY** means Fidelity Life Association, a Legal Reserve Life Insurance Company.

**YEAR/YEARLY** means Calendar Year or Plan Year, as shown on the Schedule of Benefits.

**YOU, YOUR, YOURS** means the Employee named in the Schedule of Benefits whose coverage has become effective with Us and has not terminated.

## PART 2 – ELIGIBILITY FOR INSURANCE

### ELIGIBILITY FOR INSURANCE

To be eligible for coverage under the Group Policy, an individual must either meet the definition of Eligible Employee or meet the definition of Dependent.

### EMPLOYEE ENROLLMENT ELIGIBILITY

To become an Eligible Employee, You must:

1. Be an Eligible Employee;

2. Complete and submit, through Your Employer, an Enrollment Form, including Dependents, if any, during an enrollment period;
3. Provide any additional information We need to determine eligibility, if requested by Us; and
4. Agree to pay Your portion of the required premium, if required by the Employer.

**DEPENDENT ENROLLMENT ELIGIBILITY**

1. You may enroll Your current Dependent(s) at the same time You initially enroll.
2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.
   A. If Your new Dependent is a newborn child, coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth). To continue coverage for Your newborn child, You must notify Us within 31 days and pay the required premium.

   B. If Your new Dependent is an adopted child or a child placed in Your home for adoption, coverage will be provided and premium charged from the date of adoption or the date of placement for adoption until 31 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted child or child placed for adoption, You must submit an Enrollment Form within 31 days after the date the child is placed for adoption or the date the adoption becomes final.

**EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLEES)**

There are two types of enrollment periods for obtaining coverage under the Policy:

1. The Initial Enrollment Period is the period of time during which an Employee or Dependent is first eligible to enroll under the Policy. If You or Your Dependent are enrolling during the Initial Enrollment Period, the Initial Enrollment Period will be as follows:
   A. With respect to an Employee or Dependent at the time of the Initial Enrollment Period, You must submit an Enrollment Form not later than the 31st day after the date employment begins or on completion of the Service Waiting Period.
   B. If Your Dependent is a newborn child who is born after the Initial Enrollment Period, You must notify Us within 31 days after the newborn child's birth. Coverage will be provided and premium charged for the initial period (Initial period is from the date of birth until 31 days after the date of birth) for the child. To continue coverage for Your newborn child beyond the 31 days, You must notify Us within 31 days and pay the required premium for your newborn child. In addition to Your newborn child, You may enroll Your eligible spouse at the time You enroll Your newborn child.
   C. If Your Dependent is an adopted child or child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 31 days after the date of adoption or date of placement for adoption and any additional premium for the child that is necessary to continue coverage beyond the initial 31 day period must be paid. In addition to Your adopted child or child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted child or child placed for adoption.
   D. If You are an eligible Employee who waived coverage during the Initial Enrollment Period and get married after the Initial Enrollment Period, You may enroll both Yourself, Your newly eligible spouse and any of Your spouse's children by submitting an Enrollment Form within the first 31 days from the date of marriage.

2. A Special Enrollment Period is a period after the Initial Enrollment Period ends, if all of the following occur:
   A. You or Your Dependent were covered under a group Health Benefit Plan at the time of Your Initial Enrollment Period; and
   B. You or Your Dependent declined enrollment during the Initial Enrollment Period; and
   C. If required by Your Employer, You stated in writing that coverage under another group Health Benefit Plan was the reason that You or Your Dependent declined enrollment; and
   D. Your coverage or Your Dependent's coverage:
      1) Was under a COBRA Continuation Provision and the coverage under such provision was exhausted; or

      2) Was not under COBRA Continuation Provision and any of the following occurs:

         a. You or Your Dependent is no longer eligible for the other coverage as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment;
         b. The employer sponsoring such other coverage terminates the employer's contributions toward such coverage;

c. Your Dependent no longer qualifies as a Dependent under the other coverage;
d. The other coverage no longer offers any benefits to a class of similarly situated individuals to which You or Your Dependent belonged;
e. The other coverage terminates a benefit package option; or
f. You or Your Dependent have a claim denied due to the exhaustion of the lifetime limit on all benefits under the plan.

E. If You or Your Dependent have a Special Enrollment Period as described above, the length of the Special Enrollment Period during which You and/or Your Dependent may submit an Enrollment Form will be as follows:
1) 31 days beginning on the date of the termination of coverage or the date on which the employer contributions end; or
2) 30 days from the date on which You or Your Eligible Dependent first receives notice that a claim has been denied under the other plan due to the exhaustion of the lifetime limit on all benefits.

**LATE AND OPEN ENROLLEE ELIGIBILITY (EMPLOYEE OR DEPENDENT)**
An Employee or Dependent who does not submit an Enrollment Form during the Initial Enrollment Period and who does not qualify for a Special Enrollment Period is a Late Enrollee.

1. Late Enrollees may only enroll during the Plan's Open Enrollment period. Open Enrollment means a 31-day period provided annually during which an Employee and his/her Dependents may enroll for coverage.
2. The Effective Date of coverage for a Late Enrollee that enrolls during the Open Enrollment period under the Policy will be the first day of the month next following the date We receive the Enrollment Form. Pre-Existing Conditions will not be covered until the Late Enrollee is continuously covered under the Policy for a period of 18 months following the Late Enrollee's Enrollment Date.

**COURT ORDERED CUSTODY OF CHILDREN**
Coverage is provided to a child in the court ordered custody of an Employee on the same basis as a newborn Dependent child.

We must receive notification within 31 days of the date on which the court order establishing custody of the child was issued and any additional premiums that are due for the coverage of the child must be paid. In order to establish court ordered custody, You must send Us a copy of the court order that establishes that You have full legal custody of such child.

**ENROLLMENT**
If Your or Your Dependent is entitled to enroll during an Initial Enrollment Period or Special Enrollment Period, You must submit an Enrollment Form for Yourself and/or Your Dependent on or before the applicable enrollment deadline as described in this Certificate. You may obtain an Enrollment Form from Your Employer. The Enrollment Form must be received by Us on or before the applicable enrollment deadline as described in this Certificate in order for You not to be considered a Late Enrollee.

## PART 3 – EFFECTIVE DATE OF INSURANCE

**EMPLOYEE EFFECTIVE DATE**

Your Effective Date of coverage under the Policy, excluding Late Enrollees, will be determined as follows:

1. If You enroll for coverage when the Employer enrolls for coverage, the coverage will be effective on the Employer's Effective Date.
2. If You become eligible after the Employer's Effective Date and enroll during a Service Waiting Period, an Initial Enrollment Period or a Special Enrollment Period, coverage will be effective the first of the month next following the later of the end of any applicable Service Waiting Period or receipt of the Enrollment Form by Us.

**DEPENDENT EFFECTIVE DATE**

The Effective Date of a Dependent's coverage under the Policy, excluding a Late Enrollee, a newborn child, an adopted child, or a child placed for adoption (See Dependent Enrollment Eligibility provisions above) depends on when You enroll the Dependent. The Dependent's Effective Dates are as follows:

1. If the Dependent is eligible for coverage when the Employer enrolls for coverage, the coverage for the Dependent will become effective on the Employer's Effective Date if You enroll the Dependent for coverage at that time;

2. If You first become eligible after the Employer's Effective Date and You enroll the Dependent during Your Initial Enrollment Period, the coverage for the Dependent will be effective on the same date that Your coverage becomes effective;

3. If the Dependent is a new spouse who first becomes eligible after Your Effective Date and You timely enroll the new spouse as described above, coverage will become effective as of the first day of the month next following the date on which We receive the Enrollment Form;

4. If the Dependent is a newborn child who is born after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of birth;

5. If the Dependent is an adopted child or a child placed for adoption after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the date of the adoption or date of placement for adoption; or

6. If the Dependent qualifies as a Dependent for any other reason and first meets the definition of Dependent after Your Effective Date and You timely enroll the Dependent as described above, coverage will become effective as of the first day of the month next following the date on which We receive the Enrollment Form.

Services or supplies that are payable as Covered Charges under the Policy are covered from the Effective Date; *provided however*, services or supplies for a condition that is covered under an extension of benefits from previous health insurance coverage or other benefit arrangement will not be covered under the Policy until the extension of benefits under the prior health insurance coverage or benefit arrangement ends.

## PART 4 – MEDICAL MANAGEMENT

### HEALTH CARE COORDINATION

**Health Care Coordination** is the Policy program conducted by the Health Care Coordinator designated by Us which:

A. identifies cases involving the Insured Person in a clinical situation with the potential for catastrophic claims;
B. assesses those cases for the appropriate level of patient care and the setting in which it is received;
C. develops, introduces and implements viable Alternate Treatment Plans for those cases that maintain or enhance the quality of patient care; and
D. provides cost controls by implementing the agreed upon Alternate Treatment Plan.

The Alternate Treatment Plan is a specific written document developed by the Health Care Coordinator in charge of the case receiving Health Care Coordination. This document is developed through discussion and agreement with the Insured Person or legal guardian (if necessary), the attending Physician and Us. It includes:

A. Treatment Plan objectives;
B. course of treatment planned to accomplish those objectives;
C. responsibility of each party (Health Care Coordinator, attending Physician and Insured Person and his Family, if any) in implementing the plan; and
D. estimated cost and savings.

If We agree with the Health Care Coordinator, the attending Physician and Insured Person on an Alternate Treatment Plan, We may pay incurred Eligible Expenses at a higher Coinsurance Percentage for services and supplies specified in the Alternate Treatment Plan. In the event the approved Alternate Treatment Plan specifies services or supplies not considered as Eligible Expense under the terms and provisions of the Policy, payment of benefits under the Policy for such services or supplies shall require written approval by Us. If written approval is granted, payment of benefits under the Policy for those services or supplies shall be on the same basis as if those services or supplies were Eligible Expense.

NO INSURED PERSON IS REQUIRED TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE HEALTH CARE COORDINATOR**.**

### PROVIDER NETWORKS

Reimbursement for Covered Charges varies depending on the Provider that the Insured Person selects to provide treatment, services or supplies. An In Network Provider has affiliated with an organization, association or entity, such as a preferred Provider organization or managed care organization that has established a network of Providers in a specific Geographic Area to provide medical treatment, services and supplies at predetermined rates. An Out-of-Network Provider is a Provider who is not participating in Your Provider network. We make available selected Network(s) to provide an Insured Person an opportunity to select an In Network Provider for treatment, services or supplies. Your Employer selects the Provider network

on behalf of all Employees. If an Insured Person uses an In Network Provider, We will pay benefits for that treatment, service or supply at the In Network Provider benefit level as specified in the Schedule of Benefits. If treatment, services or supplies are obtained or received from an Out-Of-Network Provider, unless otherwise stated herein, the following applies: (i) Covered Charges will be reimbursed at the Out-Of-Network Benefit Level; (ii) Charges will be reduced to the Reasonable and Customary Charges for such treatment, service or supply before being considered a Covered Charge; and (iii) the Insured Person will be responsible for any portion of the charges that exceed the Reasonable and Customary Charges for such treatment, service or supply.

When Covered Charges are incurred from an Out-of-Network Provider for Emergency Services, benefits will be paid at the In- Network benefit level shown in the Schedule of Benefits, until the Insured Person is stabilized and can be safely transported to an In-Network Provider as determined by the utilization review manager and the attending Physician. Otherwise, benefits will be reduced to the Out-of-Network Coinsurance Percentage shown in the Schedule of Benefits.

We do not arrange or provide treatment, services or supplies. It is always the Insured Person's responsibility to select a health care Provider of their choice. We have no control over, and are not responsible for, the actions or lack of actions of any Provider or Provider organization pertaining to any treatment, services or supplies rendered to an Insured Person.

**[PRE-AUTHORIZATION PROGRAM**
The Pre-Authorization Program is a prospective review that allows Us to determine whether the medical care or health care services proposed to be provided to the Insured Person are Medically Necessary and appropriate. The Pre-Authorization Program includes a list of certain medical care and health care services that require preauthorization as a condition of Our payment to a Provider under the Policy without a penalty. On receipt of a request from a Provider for Pre-Authorization, We will review and issue a determination indicating whether the proposed medical care or health care services are preauthorized. The determination will be issued and transmitted not later than the third calendar day after the date the request is received by Us. When We have pre-authorized medical care or health care services, We will not deny or reduce payment to the Physician or health care Provider for those services based on Medical Necessity or appropriateness of care unless the Physician or Provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the proposed medical or health care services. The Pre-Authorization penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or other specified medical care or health care services when the Insured Person does not comply with Pre-Authorization. The Pre-Authorization penalty amount is in addition to the applicable Yearly Deductible Copayment and Coinsurance and does not accumulate toward any Yearly or lifetime maximum benefit amounts. If the Insured Person complies with Pre-Authorization, the Pre-Authorization penalty amount will not apply. Pre-Authorization is required of all proposed Inpatient Confinements for more than 23 hours. Pre-Authorization is also required of proposed medical care and health care services, as specified in the Schedule of Benefits below.]

**[PRE-AUTHORIZATION OF NON-EMERGENCY INPATIENT SERVICES**
To request Pre-Authorization, the Insured Person or the Insured Person's attending Physician must contact the designated Pre-Authorization service at least 48 hours prior to obtaining the requested treatment, service or supply. The Pre-Authorization service may be reached by writing; or by telephone during normal business hours each business day. The name of the Pre-Authorization service and instructions are provided to each Insured Person. The Insured Person will be requested to provide:

1. name, address and the telephone number of the attending Physician;
2. the proposed treatment plan;
3. the Insured Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Authorization service will then consult with the Insured Person's attending Physician. If the Pre-Authorization service concurs with the Insured Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-Authorization service will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Authorization requirement described herein.

The Pre-Authorization service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring an Insured Person's progress on a daily basis to determine if the Insured Person will be discharged within the pre-authorized number of days and to determine the appropriate number of additional days of stay that may be required according to the Insured Person's condition and plan of treatment. Hospital admissions will be monitored to assure that the Insured Person will be discharged timely. The attending Physician and the Hospital utilization review nurses will be contacted to determine the progress of the Insured Person and the need, if any, for an extension of authorized Hospital days. If an extension of the Inpatient stay is not authorized for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

In absence of Pre-Authorization, benefits are subject to the penalty as specified in Your Schedule of Benefits.

No benefits will be paid for Covered Charges incurred for any Inpatient Hospital confinement or treatment plan which extends beyond the number of days deemed by the Pre-Authorization service to be Medically Necessary.

**Pre-Authorization is not a guarantee of payment; however we will not deny or reduce payment to the Physician or Provider for those Covered Charges based on Medical Necessity or appropriateness of care. Payment of benefits will be determined by Us in accordance with and subject to all the terms, conditions, limitations and exclusions of the Policy.**

If the Pre-Authorization service does not concur with the Insured Person's Physician, the Pre-Authorization service will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the Pre-Authorization requirement described herein and the additional deductible or limitation on extended number of days will apply.]

**[PRE-AUTHORIZATION OF EMERGENCY INPATIENT CARE**
Inpatient Confinements for Emergency Care must be authorized in the same manner as a non-emergency Inpatient Confinement; however, the Insured Person or the Insured Person's Physician may notify the Pre-Authorization service of the Emergency Inpatient confinement within 48 hours of the Inpatient Admission or as soon as reasonably possible and be in compliance with the Pre-Authorization requirement. The attending Physician must verify that an Emergency condition existed.

In the absence of Pre-Authorization for Emergency Care, benefits are subject to the additional deductible specified in the Schedule of Benefits.

If an Insured Person is taken to an Out-Of-Network Provider Hospital for Emergency Care, Inpatient Hospital Confinement benefits will be paid by Us at the In Network level of benefit as specified in the Schedule of Benefits. However, the Insured Person must arrange transfer to an In Network Hospital within 48 hours, or as soon as the transfer may take place without detriment to the Insured Person's health. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level. ]

**[PRE-AUTHORIZATION OF PREGNANCY**
You are not required to obtain Pre-Authorization for Pregnancy or for a post-delivery Inpatient confinement of 48 hours or less for a vaginal delivery or 96 hours or less for delivery by Cesarean Section.

If, following delivery, Your Physician determines that You need to remain confined in a Hospital for more than 48 hours following vaginal delivery or 96 hours following delivery by Cesarean Section, You or Your Physician must notify the Pre-Authorization service of the continuing Hospital Inpatient confinement as soon as reasonably possible following the determination to continue Your Hospital Inpatient Confinement.]

**[PRE-AUTHORIZATION OF OTHER NON EMERGENCY MEDICAL CARE OR HEALTH CARE SERVICES**
Pre-Authorization is required in order to receive benefits for the care, treatment and services listed below without a penalty. The Insured Person is responsible for assuring that the required Pre-Authorization is received before the charges are incurred by calling the designated Pre-Authorization service. Failure to comply with the Pre-Authorization requirement will result in assessment of the penalty shown in the Schedule of Benefits.

The Insured Person must obtain Pre-Authorization for the following other non-emergency medical care or health care services:

Alcohol or Chemical Dependency treatment
Cardiac and Pulmonary Rehabilitation
Durable Medical Equipment, Orthotics, Prosthetics
Elective Surgery
Home Health Care
Hospice Care
Inpatient Rehabilitation
Mental Illness treatment
Occupational Therapy
Organ Transplant
Outpatient Angiographic Procedures
Outpatient MRI
Outpatient Nuclear Imaging
Outpatient Surgery
Physical Therapy
Same Day Surgery
Skilled Nursing Care
Speech Therapy]

## PART 5 – BENEFIT PROVISIONS

We will pay Covered Charges due to Injury or Sickness. Covered Charges may during a Year, be subject to Copays, the Deductible, Coinsurance Percentage and Coinsurance Limit, as shown in the Schedule of Benefits. Covered Charges must be incurred while this coverage is in force, and are subject to the terms, conditions, limitations, exclusions, and maximums stated in the Policy, this Certificate and the Schedule of Benefits.

**In-Network.** Covered Charges incurred from Preferred Providers will be paid according to the Copay, Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for In-Network Services, and will be based on the Negotiated Rate.

**Out-of-Network.** Covered Charges incurred from an Out-of-Network Provider will be paid according to the Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits for Out-of-Network services, and will be based on Reasonable and Customary Charges.

**BENEFITS MAY BE REDUCED WHEN SERVICES ARE RECEIVED OUT-OF-NETWORK. THIS MAY INCLUDE AN ADDITIONAL DEDUCTIBLE, REDUCED COINSURANCE PERCENTAGE AND A HIGHER COPAYMENT.**

**Using Your ID Card.** Your ID card identifies You as an Insured Person in the PPO program. You are responsible for showing Your ID card to the Provider at the time of service. If You fail to show Your card before receiving any medical services, the Provider may not recognize You as a PPO Insured Person and Your benefits may be subject to the Out-of-Network Copay, Deductible, Coinsurance Percentage and Coinsurance Limit as if they were rendered by an Out-of-Network Provider.

**Use Any Provider You Choose.** You are not required to seek treatment from a PPO Provider. Each Insured Person is free to elect the services of any Provider and benefits payable will be in accordance with the terms and conditions of Your coverage under the Policy.

We do not represent Physicians or warrant the medical competence or ability of a PPO Provider, or their respective staff, nor do We have any liability or responsibility for any actions or inactions of a PPO Provider or their staff.

**Maximum Benefit.** The maximum amounts of benefits payable to, or on behalf of, each Insured Person for all Injuries and Sicknesses are shown in the Schedule of Benefits.

**Deductibles.** The Deductibles listed in the Schedule of Benefits will apply only once during a Year.

## PART 6 – COVERED CHARGES

Covered Charges are the Negotiated Rate or those Reasonable and Customary Charges incurred for services and supplies listed below which are Medically Necessary. A Covered Charge is "incurred" on the date the service or treatment is provided or the supply is obtained. Covered Charges must be incurred while Your coverage is in force. The following benefits are paid for Covered Charges at the levels indicated in the Schedule of Benefits.

### 1. INPATIENT FACILITY SERVICES

Benefits are payable for the following Inpatient Hospital Services:

A. Room, board and general nursing service, when You occupy:

1) a Hospital room with 2 or more beds, known as a semi-private room or ward; or
2) a private room. The amount of benefits for a private room is limited to the Hospital's semi-private room rate, or if there is no semi-private room rate, 90% of the private room rate; or
3) a bed in a special care unit. A special care unit is a unit whose main purpose is to provide an intensive level of care for critically ill patients. Examples of a special care unit are a coronary care unit or an Intensive Care Unit.

B. Miscellaneous Services and Supplies. Examples include:

1) use of operating, and treatment rooms, and equipment;
2) drugs (excluding take home drugs);
3) administration of blood and blood processing (including the cost of blood, plasma or fractionalized blood products);
4) anesthesia, anesthesia supplies and services;
5) medical and surgical dressings, supplies, casts, and splints;
6) diagnostic services;
7) therapy services;
8) nursing services in a special care unit, other than the portion payable under Section 1 above; and
9) one visit per Physician per day during a covered Hospital confinement due to an Injury or

Sickness.

**2. SURGICAL SERVICES**

Benefits are payable if You require surgery due to an Injury or Sickness. The surgery must be performed in a Hospital, Hospital Outpatient department or Ambulatory Surgical Center or Physician office. The following services are eligible for coverage:

**A.** **Surgical Services.** Services must be performed by a Physician. Additional payment will not be made for related pre- and post- operative care billed separately by the Physician which would or should be customarily included as part of the fee for the surgery. Benefits for surgical services will be paid as follows:

1) **Single Surgical Services.** When a single surgical service is provided by 2 or more Physicians, the benefit will be the same as if the surgical care was rendered by one Physician.
2) **Multiple Surgical Services.** The benefit payable if 2 or more surgical services are performed at the same time through different openings or approaches, is the sum of the following amounts: the greatest Covered Charge for one of the surgical procedures, plus one-half of the Covered Charge for each of the other surgical services performed.

**B.** **Surgical Assistant.** Services of a Physician who actively assists the operating surgeon in the performance of surgery are covered. The benefit payable will not exceed [20%] of the benefit amount payable for the primary surgeon's fee. No coverage will be provided for a Physician on call or placed on standby.

**C.** **Anesthesia.** Benefits are payable for the administration of anesthesia ordered by the attending Physician and rendered by a Physician in connection with a covered service. If a Certified Registered Nurse Anesthetist (CRNA) is utilized, total benefits for the Anesthesiologists and the CRNA will be limited to the Reasonable and Customary amount of the Anesthesiologist for the anesthesia service. If the only charge submitted for payment is for the services of a CRNA, then benefits will be limited to the Reasonable and Customary Charge of a CRNA for the anesthesia service.

**D.** **Miscellaneous Services.** Benefits are payable for Covered Charges for the following services provided and supplies obtained in the course of receiving surgical services.

1) the processing and administration of blood and blood components, and for whole blood, blood plasma and blood products that are not replaced by a donor for an Insured Person;
2) heart pacemaker;
3) medical and surgical dressings, casts, splints, braces, and crutches;
4) oxygen and other gases, as well as charges for their administration;
5) nursing services in an Ambulatory Surgical Center; or
6) the use of operating and treatment rooms, and equipment, in an Ambulatory Surgical Center.

**3. PHYSICIAN OFFICE VISITS**

Benefits are payable for Physician Office Visits.

In-Network Physician Office charges for examination, evaluation or consultation will be subject only to the Physician Office Visit Copay amount, limited to one office visit per day. However, charges for other treatment received during a Physician Office Visit are subject to the In-Network Deductible, Coinsurance Percentage and Coinsurance Limit.

Out-of-Network charges will be subject to the Out-of-Network Deductible, Coinsurance Percentage, and Coinsurance Limit shown in the Schedule of Benefits.

**4. HUMAN ORGAN, TISSUE, AND BONE MARROW TRANSPLANTS**

Benefits are payable for human organ transplant or tissue transplant or replacement. However, the only human organ transplants considered to be Covered Charges are those that are not considered Experimental.

An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person’s transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

If the Insured Person receives a covered human organ or tissue transplant, the donor's expenses will be considered to be the Insured Person's expenses even if the donor is also insured under the Policy as an Employee or Dependent. We will pay benefits for the donor's Covered Charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor.

**5. DIAGNOSTIC TESTING SERVICES**

Benefits are payable for diagnostic tests including related professional fees, incurred on a non-Inpatient basis. Diagnostic tests include: x-rays, laboratory tests, electrocardiograms (EKGs) and electroencephalograms (EEGs).

**6. SPECIALTY DIAGNOSTIC SERVICES**

Benefits are payable for specialty diagnostic tests, including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

**7. REHABILITATION SERVICES**

Benefits are payable for Rehabilitative Services as shown in the Schedule of Benefits including intensive physical, or speech therapy to treat acute conditions or Injuries, which are provided in a rehabilitative unit of a Hospital or a Rehabilitative Facility, when ordered by the treating Physician and provided by a licensed or registered therapist or physiatrist. To be eligible for coverage, services must begin within 7 days of a discharge from a covered acute care Inpatient Hospitalization and must be related to the Injury or Sickness resulting in the Hospitalization. We will evaluate the Medical Necessity of such services by monitoring progress toward expected outcome(s). Coverage for Rehabilitation Services will cease when progress toward the established rehabilitation outcome(s) has plateaued or the outcome(s) can be achieved utilizing a less intensive setting. The maximum number of days covered for Inpatient Rehabilitation Services per Injury or Sickness will not exceed the amount shown in the Schedule of Benefits.

**8. THERAPY SERVICES**

Benefits are payable for the services of a physical therapist, Occupational Therapist, inhalation therapist (respiratory) and speech therapist. Outpatient short-term rehabilitation, Occupational Therapy, and physical therapy services are covered when the provision of such services can be expected to result in the significant improvement of an Insured Person's condition, or the maximum benefit as shown in the Schedule of Benefits has been reached.

**9. OUTPATIENT MEDICAL THERAPY**

Benefits are payable for facility charges and professional fees incurred for radiation therapy, including treatment planning, chemotherapy, and hemodialysis therapy for treatment following a covered Hospital confinement or a covered Outpatient surgery.

**10. ALLERGY SERVICES**

Benefits are payable for allergy testing and allergy injections.

**[11. HEARING AND SCREENING SERVICES**

Benefits are payable for one routine hearing and one routine vision examination by a Physician per Year.]

**12. PROSTHETIC DEVICES**

Benefits are payable for prosthetic devices in an amount equal to the amount provided under Federal laws for health insurance for the aged and disabled, 42 USC 1395k et seq. and 42 CFR 414.202 et. seq. Covered Charges are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.

For the purposes of this benefit, the following definition applies:

Prosthetic devices means an artificial device to replace in whole or in part, an arm or a leg.

**13. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY**

Benefits are payable for breast reconstructive surgery incident to a mastectomy. Breast reconstruction shall include:

A. reconstruction of the breast upon which the mastectomy has been prescribed;
B. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. prostheses and treatment for physical complications, including lymphedemas, at all stages of mastectomy;

**14. ACUPUNCTURE AND ACUPRESSURE**

Benefits are payable as shown in the Schedule of Benefits for acupuncture and acupressure.

**15. DIABETES EQUIPMENT AND SUPPLIES**

Benefits are payable for Diabetes equipment and supplies for which a Physician has written an order including but not limited to:

A. blood glucose monitors, including non-invasive monitors and monitors designed to be used by or adapted for the legally blind;
B. test strips specified for use with a corresponding glucose monitor;
C. lancets and lancet devices;
D. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
E. insulin and insulin analog preparations;
F. injection aids, including devices used to assist with insulin injection and needleless systems;
G. insulin syringes;
H. biohazard disposal containers;
I. insulin pumps, both external and implantable, and associated appurtenances, which include:
    1) insulin infusion devices;
    2) batteries;
    3) skin preparation items;
    4) adhesive supplies;
    5) infusion sets;
    6) insulin cartridges;
    7) durable and disposable devices to assist in the injection of insulin; and
    8) other required disposable supplies;
J. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
K. Prescription Medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
L. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
M. glucagon emergency kits.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies will be covered if determined to be Medically Necessary and appropriate by a treating Physician through a written order.

All supplies, including medications, and equipment for the control of diabetes must be dispensed as written, including brand name products, unless substitution is approved by the Physician who issues the written order for the supplies or equipment.

**16. DIABETES SELF-MANAGEMENT TRAINING**

Benefits are payable for diabetes self-management training including medical nutrition education limited to:

A. Three (3) Medically Necessary visits upon initial diagnosis or if the diagnosis was made within 1 year prior to the Effective Date of this coverage, up to 3 Medically Necessary visits within 1 year after that Effective Date; or
B. up to 2 Medically Necessary visits upon a determination of a significant change in the Insured Person's symptoms or medical condition.

**17. PREGNANCY/MATERNITY**

Benefits are payable for maternity services provided to an Eligible Employee, Dependent spouse and child.

Coverage includes treatment, services or supplies furnished in connection with a routine Pregnancy and delivery by elective cesarean section for:

A. A minimum of forty-eight (48) hours after an uncomplicated vaginal delivery; or

B. A minimum of ninety-six (96) hours after delivery by uncomplicated cesarean section.

The length of stay may be shortened at the discretion of the attending Physician after conferring with the mother.

This benefit includes routine well newborn nursery care while the newborn is Hospital-confined immediately after birth and includes room, board and other normal care for which a Hospital makes a charge.

**18. COMPLICATIONS OF PREGNANCY**
Benefits are payable for Complications of Pregnancy in the same manner and to the same extent as for any other Sickness covered under the Policy.

**19. MENTAL OR NERVOUS DISORDERS**
Benefits are payable for care and treatment of Mental or Nervous Disorders in each Year to each Insured Person as shown in the Schedule of Benefits.

**20. CHEMICAL DEPENDENCY**
Benefits are payable for care and treatment of Chemical Dependency as shown in the Schedule of Benefits.

**21. SERIOUS MENTAL ILLNESS**
Benefits are payable for the care and treatment of Serious Mental Illness as shown in the Schedule of Benefits.

**22. DENTAL ANESTHESIA**
Benefits are payable for anesthetics in conjunction with dental care that is provided to an Insured Person in a Hospital or an Ambulatory Surgical Center if any of the following applies:

A. the Insured Person is a child age 6 and under;
B. the Insured Person has a medical condition that requires Hospitalization or general anesthesia for dental care; or
C. the Insured Person is disabled.

**23. AMBULANCE SERVICES**
Benefits are payable, as shown in the Schedule of Benefits, for a local, professional ambulance service to and from the nearest available Hospital or other medical facility which is appropriately staffed and equipped to treat the Insured Person's Injury or Sickness. We will not pay toward charges incurred for non-Emergency ambulance service by air unless such service is needed because of an Emergency Medical Condition. Transportation undertaken to secure treatment by a personal Physician or by a Physician or institution of greater renown or greater specialization is not covered. Preauthorization is required for non-emergency licensed ambulance services to transport an insured form a Hospital or other health care facility to another Hospital or health care facility. Services must be Medically Necessary and appropriate.

**24. EMERGENCY SERVICES**
Benefits are payable as shown in the Schedule of Benefits, for medical services directly provided by a health care Provider to treat an Insured Person’s Medical Emergency.

The Emergency Services Copay applies as shown in the Schedule of Benefits.

**25. SKILLED NURSING FACILITY SERVICES**
Benefits are payable for room, board, and general nursing care while confined in a Skilled Nursing Facility if:

A. the Skilled Nursing Facility stay begins within 14 days after a Hospital stay;
B. the stay is for the same Injury or Sickness as the Hospital stay; and
C. a Physician certifies that skilled nursing care is needed for the treatment of the Insured Person's condition.

Covered Skilled Nursing Facility charges will be limited to:

A. the most common daily semi-private room rate of the Hospital where the Insured Person was last confined; and
B. the number of days per Year and the Coinsurance Percentage shown in the Schedule of Benefits.

Successive stays in a Skilled Nursing Facility will be considered to be part of one period of Skilled Nursing Facility confinement if:

A. they result from the same or related causes; and
B. they are separated by a period of less than 6 months during which the Insured Person is not confined in

either a Hospital or Skilled Nursing Facility.

**26. HOME HEALTH CARE SERVICES**

Benefits are payable for services provided by a Home Health Care Agency under a Home Health Care Plan, up to the maximum number of visits specified in the Schedule of Benefits. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit.

Covered Charges for Home Health Care are the Reasonable and Customary Charge made for the following:

A. part-time skilled nursing care;
B. physical therapy;
C. speech therapy;
D. medical supplies, drugs and medicines prescribed by a Physician;
E. laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the Policy had the Insured Person remained Hospitalized;
F. occupational therapy; and
G. respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

A. any charges excluded under Part 7 - Limitations and Exclusions;
B. full-time nursing care at home;
C. meals delivered to the home;
D. homemaker services;
E. any services of an individual who ordinarily resides in the Insured Person's home or is a member of the Insured Person's Family;
F. any transportation services; or
G. Custodial Care.

**27. HOSPICE CARE SERVICES**

Benefits are payable for care of an Insured Person with a life expectancy of six (6) months or less in a Hospice Care Program by a Hospice Team. The benefit period commences on the date the Insured Person is admitted on the referral of a Physician to the Hospice Care Program and ends six (6) months from that date, or on the date the Insured Person dies, whichever occurs first.

Covered Charges for Hospice care are the Reasonable and Customary Charges made by a Hospice Care Program, including:

A. home care services;
B. Inpatient and Outpatient medical and non-medical care;
C. emotional support services to the Insured Person; and
D. bereavement counseling to immediate insured family members (spouse, parents and children) of the Insured Person within the three (3) month period following the death of the Insured Person, not to exceed a maximum of three (3) counseling visits.

Benefits for Hospice Care are in lieu of any similar benefits provided under any other Covered Charges provision of this Part.

**28. MANIPULATIVE SERVICES**

Benefits are payable up to the maximum amount shown in the Schedule of Benefits per Insured Person for spinal manipulation, manual or electrical muscle stimulation, other manipulative or ultrasound therapy when performed by a Physician, and any other non-surgical treatment of the spine.

**29. DURABLE MEDICAL EQUIPMENT**

Benefits are payable as shown in the Schedule of Benefits for the rental or purchase of Durable Medical Equipment (DME) that improves the function of a malformed body member or prevents further deterioration of an Insured Person's medical condition. Total rental payments, if any, will be limited to the purchase price of the equipment. A Physician must prescribe the Durable Medical Equipment for an Insured Person and submit a written statement of Medical Necessity. We will pay for the replacement of Durable Medical Equipment due to normal wear and tear.

If the DME device is covered, the supplies associated with the equipment will also be covered. Maintenance is not covered for purchase or rental equipment.

Durable Medical Equipment does not include supplies for short-term use or minor ailments, equipment which may be used by all family members, or items that may increase the value of Your property. Benefits are not provided for environmental control equipment, modifications to home property such as ramps, elevators and air conditioners, seatlift chairs, automotive vehicles, or modifications to automotive vehicles.

**30. TEMPOROMANDIBULAR JOINT DISORDER**
Benefits are payable up to the maximum amount shown in the Schedule of Benefits for the care and treatment of temporomandibular joint disorder (TMJ).

**31. INFERTILITY**
Benefits are payable for the care and treatment of infertility to the extent indicated on the Schedule of Benefits.

**32. PREVENTIVE CARE**
Benefits are payable for preventive services for Insured Person, not to exceed the limits specified in the Schedule of Benefits consisting of:

A. Physician services;
B. History;
C. Physical Examination;
D. Development Assessment for Children;
E. Anticipatory Guidance for Children;
F. Laboratory Test, X-rays, Blood Pressure checks and other services for the early detection of diseases when ordered by a Physician;
G. Annual cervical pap smear;
H. Mammography
   1) one baseline mammogram examination for each female Insured Person who is at least 35, but less than 40 years of age;
   2) one mammogram examination every 2 years or more frequently if ordered by a Physician for a female Insured Person who is at least 40 but less than 50 years of age;
   3) one mammogram examination every year for a female Insured Person age 50 and over; and
I. Prostate Cancer Screening
   Benefits are payable for an annual medically recognized diagnostic examination for the detection of prostate cancer.

   Coverage includes:
   1) a physical examination for the detection of prostate cancer; and
   2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:
      a. is at least 50 years of age and is asymptomatic; or
      b. is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

**33. PRESCRIPTION DRUGS AND MEDICINES**
Benefits are payable for prescription drugs and medicines on Our Formulary which are in excess of the Co-payment per prescription order and Yearly Deductible Amount specified in the Schedule of Benefits. Prescription drugs and medicines not on Our Formulary are not covered.

Our Formulary is a list of Generic and Brand Name Drugs that has been developed by a pharmacy and Therapeutics committee comprised of Physicians, pharmacists and other health care professionals.

This Benefit is not considered as Covered Charges under any other Benefit of the Policy. Payment of any benefits under this Benefit does not waive, or in any manner whatsoever affect, any Limitations and Exclusions of the Policy, including the Pre-Existing Condition Limitation.

**Outpatient Covered Prescription Drug Charges**
Outpatient covered Prescription Drug charges are those incurred by an Insured Person for Federal Drug Administration (FDA) approved drugs on our Formulary which are: lawfully obtainable only upon the written prescription of a Physician, not excluded below, and obtained from a licensed pharmacist.

Coverage is provided for contraceptive drugs approved by the United States Food and Drug Administration if this option is shown on the Schedule of Benefits.

**Injectable and Specialty Medications**
Injectable and Specialty Medications are covered if this option is shown on the Schedule of Benefits. To obtain Injectable and Specialty Medications, the Insured Person must contact a pharmacy Provider designated by Us as a specialty pharmacy Provider. If the Insured Person obtains the benefit from a Provider other than the specialty pharmacy Provider designated by Us, the Insured Person must pay for the services and will be reimbursed at the Negotiated Rate then in

force for the specialty Provider. Benefits are subject to the Deductible, Coinsurance Percentage, Coinsurance Limit, and lifetime maximum benefit.

Outpatient Prescription Drugs are separated into three categories:

A. **Generic Drugs.** These are Prescription Drugs that are chemically and therapeutically equivalent to brand name Prescription Drugs in the same class but are not protected by a patent. The FDA approves generic Prescription Drug as bioequivalent - meaning they perform in Your body the same as a brand preferred and/or brand non-preferred Prescription Drug. These Prescription Drug's are generally less costly than their brand-name counterparts.

B. **Brand Preferred Drugs.** Brand-name Prescription Drugs that have been determined to be superior or equal to brand non-Preferred Prescription Drugs, but are more cost effective.

C. **Brand Non-Preferred Drugs.** These brand-name Prescription Drugs have a more cost-effective therapeutic alternative.

Refer to Your Schedule of Benefits for the benefit level of each category.

If Your Physician writes a prescription that indicates a generic Prescription Drug may be substituted for a brand-name Prescription Drug and the Insured Person elects to obtain the brand name Prescription Drug instead of the generic Prescription Drug equivalent, the Insured Person will be responsible for the Insured Person's brand-name Co-payment plus the difference between the cost of the generic Prescription Drug and the brand-name Prescription Drug.

The list of Brand Preferred drugs is subject to change without notice. In addition, some drugs listed on the Brand Preferred list may not be covered Prescription Drugs in the Policy. Please refer to the list below for excluded Prescription Drugs.

**Pharmacy Benefit Manager**

A Pharmacy Benefit Manager (PBM) administers Your Outpatient Prescription Drug Benefit Rider. The PBM has contracted with a network of In Network pharmacies to dispense Outpatient Prescription Drugs at contracted rates.

A. If the dispensing Pharmacy is a member of the PBM, the Insured Person must show his or her Prescription Drug card to the Pharmacist (or where applicable, to the Physician) and pay the amount specified in the Schedule of Benefits based on the type of Outpatient Prescription Drug and the level of coverage available as specified in the Schedule of Benefits. The Pharmacy will then bill the PBM for the balance of the charges.

B. If the dispensing Pharmacy is not a member of the PBM, or if the Insured Person elects not to use his or her Prescription Drug card, the Insured must complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the PBM, which will then reimburse the Insured Person as though the prescription card had been utilized.

In Network Pharmacies provide the PBM with negotiated discounted rates. If the dispensing pharmacy is not a member of the PBM, or if the Insured Person does not use his or her Prescription Drug card, the Insured Person will be reimbursed on the same basis as would have been paid by the PBM to an In Network Pharmacy.

An Insured Person is responsible for the payment of the following if the Prescription Drug was dispensed by an Out-of-Network pharmacy or where the Prescription Drug is dispensed at an In Network Pharmacy, but the Insured Person elects a brand-name Prescription Drug when an equivalent generic Prescription Drug is available:

A. Any Co-payment, Deductible and Coinsurance as specified in the Schedule of Benefits;

B. The additional amount over what We would have paid a participating dispensing pharmacy;

C. The additional cost of any Prescription Drug which, at the request of the Insured Person or attending Physician, is not dispensed in accordance with the Maximum Allowable Cost list;

D. Prescription Drugs which are dispensed in excess of the dispensing limitation.

**Dispensing Limitation**

In order for expenses for Outpatient Prescription Drug to be considered Covered Charges , the dispensing Pharmacy may not dispense more than the following at one time:

A. For other than prescription mail orders - a 34-day supply, or 100 unit doses; or

B. For prescription mail orders - a 90-day supply.

**Right Of Recovery**

We have the right to recover by direct payment from an Insured Person any expenses for Outpatient Prescription Drug paid by Us to the extent of the number of days, or doses, dispensed to the Insured Person beyond the date of insurance termination by reason of non-payment of premium.

**Excluded Drugs**

A. Over-the-Counter Drugs and Products, except diabetes drugs;
B. Fertility Agents or drugs for sexual dysfunction;
C. Vitamins (other than pre-natal);
D. Anti-Smoking aids, e.g. Nicorette, Nicaderm, Habitrol;
E. Hair loss medications, e.g. Rogaine, Monoxidil;
F. Immunization agents, biological sera, blood or blood plasma;
G. Investigational use or Experimental drugs;
H. Any charge for administration of injectable insulin;
I. Drugs covered under Workers' Compensation;
J. Anorectica drugs for weight control;
K. Medication taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Extended Care Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing pharmaceuticals;
L. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
M. Homeopathic medications;
N. Any drugs purchased outside the United States of America;
O. Abortifacients or other drugs or devices that terminate a pregnancy; or
P. Any drugs or medicines not on Our Formulary.

## PART 7 – EXCLUSIONS AND LIMITATIONS

No benefits are payable for services, procedures, supplies, drugs, devices or treatment that are not Covered Charges or specifically provided in the Benefits sections of this Certificate.

In addition, no benefits are payable for, or relating to, the following services, procedures, supplies, drugs, devices or treatments, regardless of Medical Necessity:

1. **Absence of Insurance** – expenses for a loss for which no charge would be made in the absence of health care coverage or for a service which your Physician advertises as a free service.
2. **Acupressure/Acupuncture** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
3. **Addiction** – expenses related to nicotine addiction, caffeine addiction and non-chemical addictions including, but not limited to, gambling, sexual, spending, shopping, working and religious.
4. **Blood Storage** – expenses related to the storage of blood, except for autologous collection in preparation for surgery.
5. **Chemical Dependency** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
6. **Commission of a Felony** – expenses related to treatment of an Injury or Sickness of an Insured Person that occurs during or results from the commission of a felony by the Insured Person.
7. **Contraceptives** – expenses related to contraceptive drugs unless this option is shown on the Schedule of Benefits.
8. **Cosmetic** – expenses related to Cosmetic Surgery or treatment to improve Your appearance or correct a deformity without restoring a physical bodily function, and complications resulting from Cosmetic Surgery or procedures. This exclusion does not apply to treatment of congenital anomalies of Eligible Dependents covered from birth or to craniofacial abnormalities of an Insured Dependent under 18 years of age. This also does not apply to treatment to correct conditions resulting from a covered Injury or Sickness occurring while Your coverage was in force under the Policy.
9. **Cryopreservation of bodily fluids**.
10. **Custodial Care** – expenses related to care provided in rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or Custodial Care.
11. **Dental Care** – expenses related to dental care. This exclusion does not apply to expenses resulting from a covered Injury to Sound Natural Teeth rendered within 1 year of the Injury.
12. **Durable Medical Equipment** – beyond coverage provided in Part 6 – Covered Charges and the Schedule of Benefits.
13. **Eating Disorders** – expenses related to treatment of eating disorders including, but not limited to, anorexia nervosa or bulimia beyond coverage for Mental or Nervous Disorders already provided in Part 6 – Covered Charges.
14. **Employment for Wage or Profit or Worker's Compensation –** expenses for treatment of an Injury or Sickness arising out of, or in the course of, employment for wage or profit; and expenses for treatment of Injury or Sickness

for which the Insured Person has or had a right to recovery under any Workers' Compensation or similar Law.

15. **Excess Charges** – amounts above the Reasonable and Customary Charges for the services rendered by Out of Network Providers except as provided in the Policy.
16. **Experimental Treatment** – expenses related to services that are Experimental in nature.
17. **Family Members** – expenses related to treatment or services performed by a member of Your family or any person who regularly lives in Your home. Family members include You, Your spouse, Your spouse's parents, children, sisters, and brothers.
18. **Federal Facility** – expenses related to treatment, diagnosis, or care provided while confined in a federal facility, unless You are legally obligated to pay the charges for such confinement.
19. **Foreign Travel and Residency** – expenses related to treatment, drugs or medical care received outside the United States or its possessions, unless expenses are incurred to treat an Emergency Medical Condition while on a trip of not more than 60 days.
20. **Growth Hormones** – expenses for treatment, medication or hormones intended to stimulate growth, unless Medically Necessary.
21. **Hearing Expenses** – expenses related to routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; and the surgical or non-surgical treatment for the improvement of hearing including, but not limited to, the insertion of hearing aids or implants; [beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.]
22. **Home HealthCare and Hospice Care** – expenses related to Home Health Care and Hospice Care beyond coverage already provided in Part 6 – Covered Charges and the Schedule of Benefits.
23. **Homeopathy**.
24. **Human Organ, Tissue and Bone Marrow Transplant Benefits** – expenses relating to, or arising from, Human Organ, Tissue and Bone Marrow Transplants beyond coverage provided in Part 6 – Covered Charges and the Schedule of Benefits.
25. **Hypnosis** – expenses related to hypnosis, including its use in place of anesthesia.
26. **Infertility** – expenses related to the treatment of infertility, reversal of voluntary sterilization, or fertilization procedures [except as indicated on the Schedule of Benefits].
27. **Internet** – expenses related to treatment, diagnosis, or care provided over the Internet, or via electronic mail.
28. **Liposuction** – expenses related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti repair is associated with an umbilical or ventral hernia.
29. **Manipulative Services** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
30. **Mental or Nervous Disorders** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
31. **Non-Covered Charges** – expenses related to any benefit not specifically provided within the Policy and this Certificate.
32. **Non-Medical Expenses** – non-medical expenses, even if recommended by a Physician. This includes, but is not limited to: work hardening or strengthening programs; travel expenses; self-help training; services or supplies at a health spa or similar facility; a personal trainer; massage therapy; elastic bandages; support hose; shoes, shoe inserts, and pressure garments; personal hygiene and convenience items; water aerobics and cybex machines; television, telephone, cots and visitors' meals; charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form and information required to process Your claims and similar expenses.
33. **Outpatient Prescription Drugs** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
34. **Physical therapy, Occupational Therapy and speech therapy** – beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
35. **Preventive Care –** beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.
36. **Private Duty Nursing services** – except when such services are required for Home Health Care (see Part 6 – Covered Charges).
37. **Research** – expenses related to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research or clinical research study.
38. **Routine physical examinations** – expenses related to routine physical examinations including immunizations, use of prophylactic injections including gammaglobulins and flu shots, and well-child care including immunizations except as specifically provided in Part 6 – Covered Charges and the Schedule of Benefits.
39. **Self-Harm** – expenses related to treatment of self-inflicted Injuries or Sicknesses or attempted suicide, whether sane or insane; except as a result of a medical condition.
40. **Serious Mental Illness** – [beyond the benefit limits stated in Part 6 – Covered Charges and the Schedule of Benefits.]
41. **Sexual Dysfunctions** – expenses related to gender identity disorders, gender reassignment or sex transformation, sexual dysfunctions or inadequacies. This exclusion includes sexual therapy and counseling,

penile prosthesis and all other procedures, equipment and drugs developed for male impotency.

42. **Take Home Prescription Drugs** – expenses relating to non-prescription drugs or any take home prescriptions.
43. **Temporomandibular Joint Dysfunction (TMJ)** – expenses relating to the treatment of temporomandibular joint dysfunction and cranomandibular joint dysfunction beyond the benefit lmimits stated in Part 6 – Covered Charges and the Schedule of Benefits.
44. **Travel Expenses** – beyond coverage already provided in Part 4 - Medical Management.
45. **Vision** – No benefits are payable for expenses related to
    A. Eye refractions or eye examinations, eye glasses or contact lenses beyond the benefit limits stated in Part 6 – Covered Charges is attached to the Schedule of Benefits. This exclusion does not apply to initial prosthetic lenses, or sclera shells following intra-ocular surgery.
    B. No benefits are payable for radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy, that are not performed in connection with an Injury or Sickness.
46. **Voluntary Abortion** – except if the mother would have a Life-Threatening condition if the fetus were carried to term.
47. **War** – expenses related to Injuries, Sicknesses, diseases or disorders as a result of war or act of war, declared or undeclared.
48. **Weight** – expenses related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, or surgery for removal of excess skin or fat.

**PRE-EXISTING CONDITIONS LIMITATIONS**

Coverage for an Insured Person is subject to the Pre-Existing Condition limitations which are as follows:

1. For Insured Persons who enroll during the Initial Enrollment Period or Special Enrollment Period, Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 12 months after the Enrollment Date. A Pregnancy will not be considered a Pre-Existing Condition; and

2. For Insured Persons who enroll outside an Initial Enrollment Period or Special Enrollment Period (Late Enrollees), Covered Charges incurred for the treatment of Pre-Existing Conditions will not be covered under the Policy for a period of 18 months after the Effective Date. A Pregnancy will not be considered a Pre-Existing Condition.

A newborn child enrolled within 31 days of birth or with continuous Creditable Coverage from the date of birth if not born while Your coverage under the Policy is in effect, will not be subject to the Pre-Existing Condition limitation.

An adopted child or a child placed for adoption who is enrolled within 31 days of adoption or within 31 days from the date of placement for adoption will not be subject to the Pre-Existing Condition limitation.

**Credit for Period of Previous Health Insurance**

If on the date You enroll, You have Creditable Coverage that terminated no more than 63 days prior to Your Enrollment Date, You will be given credit for the full or partial satisfaction of the Pre-Existing Condition limitation period. Any period that You were in a Service Waiting Period prior to the effective date of Your coverage under the Policy will not be counted in determining whether You had a break in coverage that exceeded 63 days.

If You had 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be eliminated in its entirety. If You had less than 12 months of prior Creditable Coverage, the Pre-Existing Condition limitation period will be reduced by each month or partial month for which You had prior Creditable Coverage.

## PART 8 – COORDINATION OF BENEFITS

**Applicability**

1. This Coordination of Benefit ("COB") provision applies to the Policy ("This Plan") when an Insured has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the order of benefit determination rules ("Rules") should be looked at first. Those Rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
    A. shall not be reduced when, under the Rules, This Plan determines its benefits before another Plan; but
    B. may be reduced when, under the Rules, another Plan determines its benefits first.

**Definitions**

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
    A. Group insurance or group-type coverage, whether insured or self-insured. This includes: (1) prepayment; (2) group or individual practice; (3) individual and group type automobile. This does not include: (1) student accident; (2) blanket; or (3) franchise individual;

B. Coverage under a governmental plan (including Medicare) where required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time.) It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under a. or b. above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is the part of the Policy that provides benefits for health care expenses.

3. "PRIMARY PLAN"/"SECONDARY PLAN." The Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan: (a) may be a Primary Plan as to one or more other Plans; and (b) may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense." This means a Necessary, Reasonable, and Customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition. That is unless the patient's stay in a private Hospital room is Medically Necessary either: (a) in terms of generally accepted Medical practice; or (b) as precisely defined in the Plan.

A Plan might provide benefits in the form of services. In this case the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period." This means a Year. But, it does not include any part of a year: (a) during which a person has no coverage under This Plan; or (b) before the date this COB provision or a similar provision takes effect.

**Effect on Benefits**

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
   A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
   B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

   exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

**Order of Benefit Determination Rules**

1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
   A. the other Plan has Rules coordinating its benefits with those of This Plan;
   B. both those Rules and This Plan's Rules, in item 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. Rules. This Plan decides its order of benefits using the first of the following rules which applies:
   A. Non-Dependent/Dependent. The benefits of the Plan that covers the person, other than as a dependent, are determined before those of the Plan that covers the person as a dependent except that, if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      1) secondary to the Plan covering the person as a dependent; and

2) Primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering the person as other than a dependent.

B. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 2. c. below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, the other Plan may not have the rule described above. Instead it may have a rule based upon the gender of the parent. If so, and if, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will decide the order of benefits.

C. Dependent Child/Separated or Divorced Parents. Two or more Plans may cover a person as a dependent child of divorced or separated parents. In this case benefits for the child are determined in this order:

1) first, the Plan of the parent with custody of the child;

2) the Plan of the spouse of the parent with the custody of the child; and finally

3) the Plan of the parent not having custody of the child.

However, the specific terms of a court decree might state that one of the parents is responsible for the health care expenses of the child. In this case if the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This item does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

D. Dependent Child/Joint Custody. If the court decree awards joint custody, then benefits are paid as in 2.b. above.

E. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (nor as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent.) The other Plan might not have this rule. If so, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

F. Longer/Shorter Length of Coverage. If none of the above rules decides the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter time.

G. Continuation Coverage: If a person whose coverage is provided under a right of continuation plan pursuant to federal or state law and also under this Plan, the following order of benefits applies:

1) First, the Plan covering the person as an employee, or as the employee's dependent;

2) Second, the benefits of the continuation coverage.

If the other Plan does not have this rule and the Plans do not agree on the order of benefits, this rule is ignored.

**Effect on the Benefits of this Plan**

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.

2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

A. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

B. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

**Right to Receive and Release Needed Information**

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need and to obtain them from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

**Facility of Payment**
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the forms of services. In such a case "payment made" means reasonable cash value of the benefits provided in the form of services.

**Right of Recovery**
The amount of the payments made by Us might be more than We should have paid under this COB provision. In such a case, We may recover the excess from one or more of these:

1. Any persons to, or for whom, such payments are made; or
2. Any insurance companies; or
3. Any other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services. The right of recovery does not include liability settlements. However, the right will not apply unless the Insured Person, whose loss is the basis for applying such provision, is made whole.

Any such right of reimbursement provided to Us under the Policy shall not apply or shall be limited to the extent that states or the state courts eliminate or restrict such rights.

**Medicare Coordination**
1. Claims will be coordinated with Medicare based on the Medicare Secondary Payor (MSP) Rules.
2. For Employers with 100 or more Employees, this Plan will be the Primary Plan for totally disabled Employees that are covered under this Plan while entitled to Medicare disability benefits.
3. If the Insured Person is retired or on COBRA, Medicare is the Primary Plan and this Plan will be secondary for the Employee and the Employee's enrolled Dependents who are age 65 or over or eligible for Medicare because of disability. Medicare is considered a Plan for the purposes of Coordination of Benefits. The Plan will coordinate benefits with Medicare whether or not the Insured Person or the Insured Person's enrolled Dependents are actually receiving Medicare benefits.
4. The Plan is the Primary Plan and Medicare will be the Secondary Plan for an Employee and the Employee's enrolled Dependents during the first thirty (30) months in which the Employee or the Covered Dependent spouse or child(ren) is/are eligible for Medicare solely because of permanent kidney failure. After the first thirty (30) months, Medicare will be the Primary Plan and this Plan will be the Secondary Plan. Medicare will be considered a Plan for purposes of Coordination of Benefits. This Plan will coordinate benefits with Medicare whether or not the Insured Person or his Dependent spouse or child is/are actually receiving Medicare benefits.

## PART 9 – PREMIUM PAYMENT

**Payment Of Premium**
Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Employer must timely pay the monthly premium in order to maintain the Policy. The payment of any premium will not keep the Policy in force beyond the due date of the next premium, except as provided in the Grace Period. If any premium is not received by Us before or at the end of the Grace Period, the Policy will automatically end at the end of the period for which the last premium payment has been paid.

**Grace Period**
The Employer is entitled to a grace period of 31 days for the payment of any Premium due except the first, during which grace period the Policy shall continue in force, unless the Employer has given the Company written notice of discontinuance of the coverage in advance of the date of discontinuance in accordance with the terms of the Policy. The Employer shall be liable to the Company for the payment of a pro rata Premium for the time the coverage was in force during such grace period.

**Premium Changes**
We reserve the right to change premiums under the Policy on any premium due date by giving the Employer at least 31 days prior written notice.

If the Employer has selected a rate guarantee period when applying for coverage under the Policy, the premium will not change during the rate guarantee period except for the following reasons:

1. The addition or deletion of Employees to or from the coverage under the Policy;
2. An Employee enters into a new age rate-band;
3. The Employer changes the network to a network that is different than the network the Employer selected when applying for coverage;
4. The Employer moves to a different location from where the Employer was located at the time the Employer applied for coverage;
5. The Employer requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
6. New state or federal statutes, rules or regulations become effective after the Effective Date of coverage and affect Our liability under the Policy.

## PART 10 – RENEWABILITY AND TERMINATION

**Renewability of the Policy**
The Policy is on a monthly renewable basis at the option of the Employer, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of or by the Employer, or with respect to coverage of an Insured, fraud or intentional misrepresentation by the Insured or such person's representative;
3. For failure to comply with Policy provisions, including failure to provide proof, whenever requested by Us, that the Employer is complying with the Employee contribution and participation requirements;
4. For not maintaining Employee participation requirements for at least six consecutive months ;
5. For not maintaining Employee contribution requirements;
6. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would not be in the best interests of the Policyholder or certificateholders;
7. The Insurance Commissioner of the state of the Employer's residence finds that the continuation of coverage would impair Our ability to meet Our obligations;
8. The type of coverage under the Policy is no longer offered by Us in the state of the Employer's residence in which event We will provide ninety (90) days prior written notice of the discontinuance and We will offer the Employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the large group market in that state.
9. We decide to discontinue offering all health insurance in the large group market in the state of the Employer's residence in which event We will provide the applicable State authorities and the Employer written notice 180 days prior to the discontinuation and We will discontinue all health insurance issued or issued for delivery in the large group market in the state of the Employer's residence and will not renew such coverage in the state of the Employer's residence.

**Time For Non-Renewal of the Policy**
All insurance under the Policy for an Employer, its Employees and their Dependents shall be non-renewed as follows:

1. Lapse due to non-payment of premium, at 12:01 A. M., of the premium due date following the end of the month for which the last premium payment is made on account of the Employer's insurance; or
2. Non-renewal for all other reasons, at 12:01 A. M., of the premium due date coinciding with or next following the date such event took place.

**Termination Of Employee's Coverage**
Coverage for an Insured Employee shall automatically terminate on the earliest of the following dates:

1. The date of termination of the Policy; or
2. The date of termination of any section or part of the Policy with respect to insurance under such section or part; or
3. The last day of the month in which You no longer meet the eligibility criteria established in the Policy; or
4. The date You or Your Employer fails to pay the required premium; or

5. The date You enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or

6. The date You reach the Maximum Benefit as specified in the Schedule of Benefits.

**Termination Of Dependent Insurance**
Coverage for an Insured Employee with respect to Dependents shall terminate on the earliest of the following dates:

1. The date of termination of the Policy; or

2. The date of termination of any section or part of the Policy in respect to insurance under such section or part; or

3. The date Your insurance terminates; or

4. The date You or Your Employer fails to pay the required premium; or

5. The last day of the Policy Month in which a Dependent ceases to meet the definition of "Dependent"; or

6. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less or as provided by the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or

7. With respect to an Insured Employee's Dependent spouse, the premium due date coinciding with or next following the date on which the Insured Employee is divorced or legally separated from such spouse; or

8. The date the Dependent reaches the Maximum Benefit while an Insured Person as specified in the Schedule of Benefits; or

9. The premium due date coinciding with or next following the date on which a Dependent child no longer qualifies under the definition of “Dependent.” If upon attaining any limiting age specified in the definition of a Dependent, a child, because of Mental or Physical Incapacity, as defined below, is incapable of earning his or her own living and is chiefly Dependent upon the Insured Person for support and maintenance, coverage for the Dependent child may be continued during the continuance of such incapacity, providing that:

   A. Medical proof, in writing, of such incapacity must be given to Us within 31 days after the date on which the Dependent child attains a limiting age; and

   B. We shall have the right any time during the continuance of insurance under this provision to require due proof of the continuance of the incapacity and to have the Dependent child examined by Physicians designated by Us at any time during the first 2 years of such continuance and not more than once each year thereafter; and

   C. You continue paying the required premium for the Dependent; and

   D. The continuance described herein shall cease in the event of the occurrence of any of the circumstances described in paragraphs 1. through 8. above.

   For the purposes of the provision, the following definition applies:

   Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities which are demonstrated by medically acceptable clinical, laboratory or diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

**Modifications**
We may modify the Policy and this Certificate if the modification occurs at the time of coverage renewal.

## PART 11 – GENERAL PROVISIONS

**Entire Contract - Changes**

The entire contract is made up of: (a) the Policy; (b) the Employer’s Application; and (c) any individual Employee Applications. No agent, Employer, Employee, or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Insured Person and on any other individual(s) referred to in the Policy and this Certificate.

**Incontestability**

The validity of the Policy will not be contested, except for non-payment of premiums, after it has been in force for 2 years from the Date of Issue.

In the absence of fraud, a statement made by any individual covered by the policy relating to the individual's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made: (a) after the insurance has been in force before the contest for two years during the individual's lifetime; and (b) unless the statement is contained in a written instrument signed by the individual making the statement.

**Representations**
In the absence of fraud, a statement made by the Policyholder or an Insured Person is considered a representation and not a warranty; and a statement made by the Policyholder or an Insured Person may not be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to: (a) the person making the statement or (b) if the statement was made by the Insured Person and the Insured Person has died or become incapacitated, the Insured Person's beneficiary or personal representative.

**Conformity with Federal and State Laws**
Any provision of the Policy which is in conflict with Federal laws or any applicable state law is hereby amended to meet the minimum requirements of the law.

**Ambiguities**
Any terms or conditions specified in the Policy that are determined to be ambiguous or in conflict with State or Federal laws shall be considered separately and shall not void or effect the legality of the remaining terms and conditions that are included in the Policy and this Certificate.

**Physical Examination**
We have the right, at Our own expense, to have an Insured Person for whom claim Is made examined as often as is reasonable while a claim is pending under the Policy.

**Workers' Compensation**
The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

**Certificates/Booklets**
We will issue to the Employer a Certificate for delivery to each Insured Employee.

**Waiver Of Rights**
If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

**Required Information**
The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care Providers from whom the Insured Person has received treatment or services, documentation of prior Creditable Coverage, marriage license, documentation of adoption, documentation of legal custody of a Dependent, student status information, and treating Provider statements.

**Effective Date**
No insurance under the Policy shall become effective until notice in writing is given to the Employer by Us. Issuance of a Certificate with a Validation of Coverage face page will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

**Misstatement of Age**
If the age of an Insured Person has been misstated, We will make an equitable adjustment of premiums or benefits or both. We will change the benefit to the applicable amount available for the correct age. We will refund to the Employer any excess premium paid over the amount due for the correct benefit amount. We will request payment for any overdue premium for the correct benefit amount.

## PART 12 – CLAIM PROVISIONS

**Notice of Claim:** Written notice of claim must be given to Us as soon as possible. Written notice of claim given by or on behalf of the Insured to Us with information sufficient to identify such person will be considered notice to Us.

**Claim Forms:** Upon receipt of written notice of claim, We will furnish the required forms (if any) for filing proof of loss. If We do not send the forms within 15 days, You can satisfy Our requirements by giving Us a written statement. The statement should include the nature and extent of the claim, and be sent to Us in accordance with the proof of loss provision.

**Proof of Loss:** Written proof of loss must be furnished to Us within 90 days after the date the medical treatment was received. Written proof of loss includes all information necessary for Us to determine that a valid loss occurred. If it is shown that it is not reasonably possible to furnish written proof of loss within that time, the claim will not be rejected or reduced as long as We receive such proof as soon as reasonably possible, and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required pursuant to this provision.

**Timely Payment of Claims:** We will pay all benefits due for Covered Charges, promptly upon receipt of due proof of loss.

**Assignment of Claims:** All benefits payable will be payable to You unless a written assignment of benefits is filed with Us at Our administrative office. We will not be responsible for the legal effect of any assignment.

**Payment of Claims:** All benefits for Covered Charges are payable to You unless You have otherwise assigned the benefits to a medical Provider. If any such benefits remain unpaid at Your death, or, if You are, in the opinion of the Company, incapable of giving a legally binding receipt for payment of any benefit, We may, at Our option, pay such benefit to any one or more of the following relatives: Your spouse, mother, father, child, brother or sister. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

**Appeal**
Under ERISA or state law, You have certain administrative appeal rights. If You disagree with any benefit determination made by Us, You must complete all administrative appeals to which You are entitled before You may demand legal action.

**Legal Action**
No action at law or in equity will be brought to recover under the Group Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Group Policy, nor will any action be brought after 3 years from the date the claim was first incurred.

**Subrogation/Right Of Reimbursement**

As a condition to receiving benefits under this Policy, Insured Person(s) agree to transfer to Us their right to recover damages to the extent of benefits paid by Us when an Injury or Sickness occurs through the act or omission of another person. If an Insured Person received payment from another person or entity on account of, due to, or arising out of an Injury or Sickness, the Insured Person agrees to reimburse Us to the full extent of Covered Charges paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Injury or Sickness occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Insured Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Insured Person to assert a claim to any of the foregoing coverages to which the Insured Person may be entitled. Insured Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Insured Person's attorneys' fees or other costs associated with a claim/lawsuit.

# SCHEDULE OF BENEFITS / *[Options are in Brackets]*

**Policyholder:**
**Employer:**
**Insured:**
**Certificate Number:**
**Effective Date:**
**Premium Due Date: [1st of the month]**
**Schedule Date:**
**Dependent Spouse:**
**Dependent Child(ren):**
**Dependent Limiting Age: up to age 19**
**Student Eligibility Limiting Age: up to age 23**
**Pre-Existing Conditions Limitations Apply: [Yes/No]**
**Year: [Calendar] [Plan] Year**

## Medical Expense Benefits

**Lifetime Maximum Benefit** — [A combined lifetime maximum benefit of ][$1,000,000 – $5,000,000]

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| **Year:** | **[Calendar] [Plan]** | |
| **Deductible per Year [(1)]** | | |
| Individual | [$250 - $10,000] | [2x In-Network] [$500 - $20,000] |
| Family [2x Individual] | [2x individual] [$500 - $20,000] | [2x In-Network] [$1,000 - $40,000] |
| **Coinsurance for all Eligible Expenses** | [0% - 50%] | [0% - 50%] |
| **Out-of-pocket Maximum (OOP)[(2)(3)]** | | |
| Individual | [$500 - $10,000] | [2x In-Network] [$1,000 - $20,000] |
| Family [2x Individual] | [2x individual] [$1,000 - $20,000] | [2x In-Network] [$2,000 - $40,000] |
| Deductible Applies | [Yes, No] | |
| Coinsurance Applies | [Yes, No] | |
| Copayment Applies | [Yes, No] | |
| Out-of-Network Deductible & OOP apply to In-Network Deductible & OOP | [Yes, No] | |
| Out-of-Network Maximum per year: | [Not Applicable] | [Not Applicable, $500,000, $5,000,000] |
| **Physician Care** | | |
| • [Office Visit] | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • [Specialist Office Visit] | [Co-payment [$0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Lab Tests & X-rays [Major] [Minor] | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Office Surgery | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |

# SCHEDULE OF BENEFITS / ***[Options are in Brackets]***

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| • Allergy Injections | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Urgent Care | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| **Preventive Care**<br>• Physician Services<br>• History<br>• Physical Examinations<br>• Laboratory Test, X-rays, Blood Pressure checks and other services for the early detection of diseases when ordered by a Physician<br>• Annual cervical/pap smear | [Co-payment [($0 - $100)] [*] | [deductible/coinsurance] |
| Maximum Benefit per Year: | [Not Applicable] [Limited to a Calendar Year maximum of [$50 - $2,500]] | |
| **Mammography Screening** | [Co-payment ($10-$100) [Deductible/coinsurance] [Limited to [$50] per screening | [Deductible/coinsurance] |
| **Colorectal Cancer Screening** | [Co-payment ($10-$100) [Deductible/coinsurance] | [Deductible/coinsurance] |
| **Prostate Cancer Screening** | [Co-payment ($10-$100) [coinsurance] Not subject to Deductible | [Coinsurance]Not subject to Deductible |
| **Preventive and Primary Care Services for Children (Birth to age 18)** | [Co-payment ($10-$100) [Deductible/coinsurance] | [Deductible/coinsurance] |
| **Childhood Immunizations** | Not subject to copayment, deductible or coinsurance | Not subject to copayment, deductible or coinsurance |
| **Pregnancy/Maternity Care**<br>• [Office visits (pre & postnatal)<br>• [Hospitalization] | [Co-payment [($0-$100)]][*] [deductible/coinsurance] | [deductible/coinsurance] |
| **[Vision Exam – Routine]** | [Co-payment [($0-$100)]][*] [(Limited to Calendar Year maximum benefit of [$50 - $1,000])] [(Limited to max per Year benefit of [1] visits)] | [deductible/coinsurance] [Not Covered] |
| **[Hearing Exam – Routine]** | [Co-payment [($0-$100)]][*] [(Limited to Calendar Year maximum benefit of [$50 - $1,000])] [(Limited to max per Year benefit of [1] visits)] | [deductible/coinsurance] |
| **Hospitalization Inpatient Services (4)** | [Co-payment [($10 - $100]] | |

| | | |
|---|---|---|
| • Semi-private Hospital Room & Board | [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Physician & Surgeon Services | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Lab, X-ray and other facility charges | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Inpatient Rehabilitation | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| **Hospital Outpatient Surgery (4)** | [deductible/coinsurance] | [deductible/coinsurance] |
| **Outpatient Services** | [Co-payment [$0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| **Emergency Services** | | |
| • [Office Visits] | [[Co-payment [($50 - $1,000]] [deductible/ coinsurance] | [[Co-payment [($50 - $1,000]] [deductible/ coinsurance] |
| • Emergency Room ([Co-payment] waived if admitted) | [[Co-payment [($50 - $1,000)]] [deductible/ coinsurance] | [[Co-payment [($50 - $1,000)]] [deductible/ coinsurance] |
| **[Ambulance** | | |
| • Ground | [deductible/coinsurance] | [deductible/coinsurance] |
| • Air] | [Maximum benefit $50 - $10,000] [deductible/coinsurance] [Maximum benefit $0 - $25,000] | [deductible/coinsurance] |
| **Chemical Dependency [(4)]** | | |
| • Inpatient treatment of alcohol and drug dependency | [deductible/coinsurance] (Limited to $3,000 in any 2 month period, $6,000 for each 24-month period) and limited to $12,000 per covered person per lifetime [(Limited to Calendar Year maximum benefit of [10-100 visits)] | [deductible/coinsurance] |
| **Mental or Nervous Disorders** | | |
| • Inpatient | [[Co-payment [($0 - $100)]] [deductible/coinsurance] | [deductible/coinsurance] |
| • Outpatient | [deductible/coinsurance] | [deductible/coinsurance] |
| **Serious Mental Illness** | [[Co-payment [($0 - $100)]] [deductible/coinsurance] | [deductible/coinsurance] |
| **Rehabilitation Services** | | |
| • Inpatient [(4)] | [deductible/coinsurance] [Co-payment [($0-$250)]][*] | [deductible/coinsurance] |

| | |
|---|---|
| • Outpatient | [(Limited to Calendar Year maximum benefit of [30 – 60 visits] [deductible/coinsurance] [deductible/coinsurance] [Co-payment [($0-$100)]][*] |
| **Durable Medical Equipment [(4)]** | [(Limited to Calendar Year maximum benefit of [50 – 75 visits] [deductible/coinsurance] [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [$2,500 – $10,000)] [Rental limited to purchase price] |
| **Skilled Nursing Facility [(4)]** | [deductible/coinsurance] [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [30 – 270 days)] |
| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** / **Out-of-Network Cost to Covered Person** |
| **Home Health Care [(4)]** | [deductible/coinsurance] [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [30 – 180 visits)] |
| **Hospice Service [(4)]** | [deductible/coinsurance] [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of $500 - $10,000, Not Applicable)] |
| **Organ Transplant (4)** | [Co-payment [($10 - $100]] [deductible/copayment] [deductible/copayment] |
| **Manipulative Services** | [Co-payment ($0 - $100] [*] [No coverage] [deductible/coinsurance] [deductible/coinsurance] [Limited to Calendar Year maximum benefit of [$500 - $5,000])] |
| **Acupressure/Acupuncture** | [(Limited to max per Year benefit of [10 - 40 visits)] [Co-payment ($0 - $100] [*] [No coverage] [No coverage] [deductible/coinsurance] [deductible/coinsurance] [Limited to Calendar Year maximum benefit of [$500 - $5,000])] |
| **Temporomandibular Joint Dysfunction (TMJ)** | [(Limited to max per Year benefit of [10 - 40 visits)] [Co-payment ($0 - $100] [*] [Co-payment ($0 - $100] [deductible/coinsurance] [deductible/coinsurance] |
| **Infertility** | [Co-payment ($0 - $250] [*] [Co-payment ($0 - $250] [deductible/coinsurance] [deductible/coinsurance] (Limited to a lifetime maximum benefit of $15,000-$25,000])] |
| **Injectible & Specialty Medications** | [No coverage] [deductible/coinsurance] [No coverage] [deductible/coinsurance] |
| **Hearing Aids** | [coinsurance]Not subject to deductible or copayment [coinsurance]Not subject to deductible or copayment [Limited to $1,400 per ear for each 3-year period] |
| **[Prescription Drug** Rx Deductible | [deductible & coinsurance] [Not Covered] [Does not |

apply to medical deductible & out-of-pocket maximum]

| | |
|---|---|
| Prescription Contraceptive Coverage | [$0 - $200]<br>Covered |
| • **Retail and Mail Order – 34 day supply** | [Co-payment] |
| - Generic | [($5 - $50)] |
| - Brand Preferred | [($20 - $75)] |
| - Brand Non-Preferred | [($20 - $100)] |
| | [Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.] |

**[* Benefits marked with an asterisk (*) are not subject to the Calendar Year Deductible.]**

[(1) Copays do not count toward the Calendar Year deductible.]

[(2) [Deductible does [not] apply to OOP maximum.]

[(3) [Co-pay does [not] apply to OOP maximum.]

[(4) Requires Pre-Authorization. There is a penalty of [$250] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.

[The following are subject to Pre-Authorization prior to obtaining services:

Alcohol or Chemical Dependency treatment
Cardiac and Pulmonary Rehabilitation
Durable medical Equipment, Orthotics, Prosthetics
Elective Surgery
Mental Illness treatment
Occupational Therapy
Organ Transplant
Outpatient Angiographic Procedures
Outpatient MRI
Outpatient Nuclear Imaging]
Home Health Care
Hospice Care
Inpatient admissions
Inpatient Rehabilitation
Outpatient Surgery
Physical Therapy
Same Day Surgery
Skilled Nursing Care
Speech Therapy

# FIDELITY LIFE ASSOCIATION, **a Legal Reserve Life Insurance Company**
**Oak Brook, Illinois**

## ARKANSAS AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended as follows:

**A. PART 1 – DEFINITIONS**, the following definition is added:

**EMERGENCY CARE** means health care services provided in a Hospital emergency facility to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

A. Placing the patient's health in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part

**B. PART 2 – ELIGIBILITY FOR INSURANCE**, the following changes are hereby made:

1. **DEPENDENT ENROLLMENT ELIGIBILITY**, item 2. is deleted and replaced with the following:

   2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.

      a. If Your new Dependent is a newborn Child, coverage will be provided from the moment of birth and will remain in force for 90 days. To continue coverage for Your newborn Child, You must submit an Enrollment Form for Your newborn Child and pay the required premium.

      b. If Your new Dependent is an adopted Child, a Child placed in Your home for adoption, or a minor under Your charge, care, and control for whom You have filed a petition to adopt, prior to the Child's 18th birthday, coverage will be provided from the date of adoption or the date of placement for adoption until 60 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted Child or Child placed for adoption, You must submit an Enrollment Form for Your adopted Child or Child placed for adoption and pay the required premium.

2. **EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLES) ELIGIBILITY**, items 1. B and C are deleted and replaced with the following:

   B. If Your Dependent is a newborn Child, who is born after the Initial Enrollment Period, You must notify Us in writing within 90 days after the newborn Child's birth and any additional premium for the Child that is necessary to continue coverage beyond the initial 90 day period must be paid. In addition to Your newborn Child, You may enroll Your eligible spouse at the time You enroll Your newborn Child.

   C. If Your Dependent is an adopted Child or Child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 60 days after the date of adoption or date of placement for adoption and any additional premium for the Child that is necessary to continue coverage beyond the initial 60 day period must be paid. In addition to Your adopted Child or Child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted Child or Child placed for adoption.

**C. PART 6 – COVERED CHARGES** the following changes are hereby made:

1. Item **3. PHYSICIANS OFFICE SERVICES**, the following is added:

   We will not refuse to reimburse a Physician at the full rate for health care services provided by a Physician assistant if the practice complies with the laws of Arkansas. We will not impose a practice or supervision

restriction of a Physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of Arkansas.

2. Item **16. DIABETIC SELF-MANAGEMENT TRAINING**, is deleted and replaced with the following:

   Benefits are payable for services and supplies to enable a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospital care and complications. Covered Charges include services provided by a Physician or medical professional designated by the Physician. Visits for diabetic training, including medical nutrition education, are covered as follows:
   a. one (1) lifetime training program per Insured Person for diabetes self-management training when Medically Necessary as determined by a Physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the Insured Person has successfully completed the training;
   b. additional diabetes self-management training in the event that a Physician prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the Insured Person's symptoms or conditions; and
   c. diabetes self-management training shall be provided only upon prescription by a licensed Physician.

3. Item **17. PREGNANCY/MATERNITY**, the last paragraph pertaining to well newborn nursery care is deleted and replaced with the following:

   If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

4. Item **20. CHEMICAL DEPENDENCY**, is deleted and replaced with the following:

   Benefits are payable for the treatment of chemical dependency in an alcohol or drug dependency treatment facility or in a Hospital as shown in the Schedule of Benefits.

   For the purposes of this benefit the following definitions apply:

   Alcohol or drug dependency treatment facility means a public or private facility, or unit in a facility, that is engaged in providing treatment 24-hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a Physician, and that is also properly licensed or accredited to provide those services by the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health.

   Alcohol or drug dependency means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

5. Item **22. DENTAL ANESTHESIA**, is deleted and replaced with the following:

   Benefits are payable for dental anesthesia and Hospital charges for dental procedures in a Hospital or Ambulatory Surgical Center in order to safely and effectively perform dental procedures when the Insured Person is:

   A. A child under 7 years of age, and determined by two dentists to have a significantly complex dental condition;
   B. Diagnosed with a serious medical or physical condition; or
   C. Has a significant behavioral problem as determined by his or her Physician.

6. Item **23. AMBULANCE SERVICES**, the following is added:

   If an Insured Person files a claim for covered professional ambulance services, direct reimbursement will be made to the provider of the services if the provider has not received payment for those services from any other source.

7. Item **31. INFERTILTY**, the following is added:

   Benefits are payable for in vitro-fertilization procedures when:
   A. the patient is an Employee or Dependent spouse covered under the Policy;
   B. the patient’s occytes are fertilized with the sperm of the patient’s spouse;

C. the patient and the patient's spouse have a history of unexplained infertility of at least 2-years duration; or the infertility is associated with one or more of the following medical conditions:
   1) endometriosis;
   2) exposure in utero to diethylstilbestrol, commonly known as DES;
   3) blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
   4) abnormal male factors contributing to the infertility; and

D. the in vitro-fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists guidelines for in vitro-fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro-fertilization; or

E. the patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

Cryopreservation is included as an in vitro-fertilization procedure.

8. Item **32. PREVENTIVE CARE**, is deleted and replaced with the following:

Benefits are payable for preventive services for an Insured Person, not to exceed the limits specified in the Schedule of Benefits consisting of:

A. Physician services;
B. History;
C. Physical Examination;
D. Laboratory Test, X-rays, Blood Pressure checks and other services for the early detection of diseases when ordered by a Physician;
E. Annual cervical pap smear.

9. Item **33. PRESCRIPTION DRUGS AND MEDICINES** the following changes are hereby made:

1. **Outpatient Covered Prescription Drug Charges**, the following has been added:

   Coverage is provided for contraceptive drugs and devices approved by the United States Food and Drug Administration.

2. **Dispensing Limitation**, sub-item B. pertaining to prescription mail orders is deleted in its entirety.

3. The following is added:

   We will not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

   A. The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one
      1) or more such compendia:
      2) The American Hospital Formulary Service drug information;
      3) The United States Pharmacopoeia dispensing information; or
   B. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

      Coverage of such drug includes Medically Necessary services associated with the administration of the drug.

      We will not contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

We shall apply the same coinsurance, Copay, and Deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in Our network if the provider meets Our explicit product cost determination. We will not set a limit on the quantity of drugs which an Insured Person may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in Our network.

10. The following items are added:

**34. PREVENTIVE AND PRIMARY CARE SERVICES FROM BIRTH TO 18 YEARS OF AGE**

Benefits are payable for the following child preventive care services including:

1. Newborn screening tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants as mandated by law;
2. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time;
3. Children's preventive health care services are provided for covered Dependents for periodic preventive care visits from the moment of birth through 18 years of age. Coverage includes 20 visits under the supervision of a single Physician during the course of one visit, and at the following intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.
4. Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

Recommended immunization services are exempt from any Copay, coinsurance, Deductible and dollar limit provisions.

For purposes of this benefit, the following definitions apply:
Children's preventive health care services means Physician-delivered or Physician-supervised services for eligible Dependents from birth through 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits mean the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

**35. CANCER SCREENING TESTS**

Benefits are payable for the following cancer screening tests:

A. Mammography
   1) a baseline mammogram for a female Insured Person 35 to 40 years of age;
   2) a mammogram for a female Insured Person 40 to 49 years of age every one to two years based on the recommendation of the woman's physician;
   3) a mammogram each year for a female Insured Person who is at least 50 years of age;
   4) upon the recommendation of a female Insured Person's Physician, without regard to age, when the female Insured Person has had a prior history of breast cancer or when the female Insured Person's mother or sister has had a history of breast cancer; and
   5) diagnostic mammograms as recommended by the Insured Person's physician.

B. Colorectal Cancer Screening – Examinations and laboratory tests as prescribed by a Physician for:
   1) Insured Person's who are 50 years of age or older;
   2) Insured Person's who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines; and
   3) Insured Person's experiencing the following symptoms of colorectal cancer as determined by a Physician: a. bleeding from the rectum or blood in the stool; or b. a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

   An examination of the entire colon, including:
   1) The following examinations or laboratory tests, or both:

a. An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
b. A double-contrast barium enema every five (5) years; or
c. A colonoscopy every ten (10) years; and

2) Any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

The Insured Person shall determine the choice of screening strategies in consultation with a health care provider.

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

1) If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
2) For individuals with one or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
3) If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
4) For Insured Persons with large sessile adenomas greater than three (3) centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

C. Prostate Cancer Screening -- One screening per Year for the early detection of prostate cancer in a male Insured Person 40 years of age and older performed by a qualified medical professional according to National Comprehensive Cancer Network guidelines. This benefit is not subject to the Deductible.

**36. MEDICAL FOOD OR LOW PROTEIN FOOD PRODUCT**

Benefits are payable for Medical Food or Low Protein Modified Food Products for the treatment of an Insured Person inflicted with phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism if: (a) the medical food or low protein modified food products are prescribed as Medically Necessary for such treatment; and (b) the products are administered under the direction of a Physician.

For the purposes of this benefit, the following definitions apply:

Low Protein Modified Food Product means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

**37. TREATMENT OF THE BONES AND JOINT OF THE FACE, HEAD AND NECK**

Benefits are payable for treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Covered Charges include both surgical and nonsurgical procedures. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body.

**38. SPEECH AND HEARING SERVICES**

Benefits are payable for care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

**39. HEARING AIDS**

Benefits are payable as shown in the Schedule of Benefits for a hearing aid or hearing instrument sold by a professional licensed by the state of Arkansas to dispense a hearing aid or hearing instrument. This benefit is not subject to the Deductible or a Copayment.

For the purposes of this benefit, the following definition applies,
Hearing aid or hearing instrument means an instrument or device, including repair and replacement parts, that: (A) Is designed and offered for the purpose of aiding an Insured Person with or compensating for impaired hearing; (B) Is worn in or on the body; and (C) Is generally not useful to a person in the absence of a hearing impairment.

**40. PROSTHETICS AND ORTHOTICS SERVICES AND DEVICES**
Benefits are payable for eighty percent (80%) of Medicare allowables as defined by the Center for Medicare Medicaid Services, Healthcare Common Procedure Coding System as of January 1, 2009, or as of a later date if adopted by rule of the Insurance Commissioner for: (A) An orthotic device; (B) An orthotic service; (C) A prosthetic device, and (D) A prosthetic service. Benefits are not payable for an orthotic device, an orthotic service, a prosthetic device, or a prosthetic service for a replacement that occurs more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria.

An orthotic device, an orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Eligibility for this benefit is based on criteria, which include without limitation: (A) The information and recommendation from the treating Physician in consultation with the Insured Person and (B) the results of a functional limit test.

For the purposes of this benefit, the following definition applies
Functional Limit Test means (A) Medical history, including prior use of orthotic devices or prosthetic devices if applicable; (B) Current condition, including the status of the musculoskeletal system and the nature of other medical problems; and (C) Desire to: (i) Ambulate with respect to lower-limb orthotic devices or prosthetic devices; or (ii) Maximize upper-limb function with respect to upper-limb orthotic devices or prosthetic devices.

D. **PART 7 – EXCLUSIONS AND LIMITATIONS,** the following changes are hereby made:

1. Item #7 pertaining to contraceptive drugs is deleted in its entirety.

2. Item #30 pertaining to Mental or Nervous Disorders is deleted in its entirety.

3. Item #40 pertaining to Serious Mental Illness is deleted in its entirety.

4. Item #43 pertaining to Temporomandibular Joint Dysfunction is deleted in its entirety.

E. **PART 10 – RENEWABILITY AND TERMINATION,** the following are hereby added:

**Continuation of Coverage**

1. Any Insured Person whose coverage would otherwise terminate due to termination of employment or a change in marital status may continue coverage under the Policy for themselves and their eligible Dependents.

2. Continuation of coverage shall be available only to Employees who have been insured continuously under the Policy during the 3-month period prior to the termination of employment or change in marital status.

3. Continuation of coverage shall not be available to an Insured Person who is eligible for:
   A. Federal Medicare coverage; or
   B. Full coverage under any other group accident and health policy or contract.
      1) The other coverage must provide benefits for all preexisting conditions to be considered full coverage.
      2) Accordingly, an Insured Person may continue coverage under the Policy until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to paragraph 6 below or pursuant to the applicable provisions of federal law.

4. An Insured Person who wishes to continue coverage must request continuation in writing not later than 10-days after the termination of employment or the change in marital status.

5. An Insured Person who requests continuation of coverage must pay the premium required on a monthly basis and in advance.

6. Continuation of coverage will end upon the earliest of the following dates:
   A. 120-days after continuation of coverage began;
   B. The end of the period for which the Insured Person made a timely contribution;
   C. The contribution due date following the date the Insured Person becomes eligible for Medicare; or
   D. 1) The date on which the Policy is terminated.
      2) However, if the Policy is replaced by Us, continuation shall continue under the new coverage.

7. At the termination of the continued coverage, an Insured Person will be offered a conversion policy (see the Conversion section below).

8. Insured Person's choosing to utilize the Conversion privilege below may do so and thereby waive their right to continuation of coverage under this section.

**Conversion**

1. An Insured Person whose insurance under the Policy has been terminated for any reason, including the discontinuance of the Policy in its entirety, shall be entitled to have issued to him or her by Us a policy of accident and health insurance referred to in this section as a "conversion policy".

2. An Insured Person shall not be entitled to a conversion policy, if the termination of the coverage under the coverage was a result of his or her failure to pay any required contribution or if the coverage under the Policy is replaced by similar coverage within 31-days. An Insured Person wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than 30-days after the termination of coverage under the Policy.

3. The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner.

4. We shall not offer the conversion policy to any Insured Person who is eligible for:

   A. Medicare coverage; or
   B. Full coverage under any other group accident and health policy or contract. This other coverage must provide benefits for all preexisting conditions to be considered full coverage.

   Accordingly, an Insured Person may convert to a conversion policy and remain covered by that policy until all Pre-Existing conditions are covered or would be covered under another group policy or contract.

5. The initial premium for the conversion policy for the first 12-months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the age and class of risk of each person to be covered under the conversion policy and for the type and amount of insurance provided

**F. PART 11 – GENERAL PROVISIONS,** the following change is hereby made:

1. **Time Payment of Claims – Clean Claim** is added:

   We will pay, deny or settle all benefits due for clean claims within 30 calendar days after receipt of proof of loss submitted electronically or within 45 days by any other method.

   If the resolution of a claim requires additional information, We will, within 30 calendar days after receipt of the claim, give the Employee a full explanation of what additional information is needed. If the Employee and the Provider have provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within 30 calendar days after receipt.

If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

For the purpose of this provision, the following definition has been added:

"Clean Claim" means a claim that is submitted on a HCFA 1500 or on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the Plan's standard claim form with all required fields completed in accordance with the Plan's published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, or (2) for which the Plan needs additional information in order to resolve one or more outstanding issues.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

**FIDELITY LIFE ASSOCIATION, a Legal Reserve Life Insurance Company**

[ ][ ]

**SECRETARY** **PRESIDENT**

# EMPLOYER GROUP APPLICATION

(Becomes part of the Group Policy)

[Product Logo]

Underwritten by: FIDELITY LIFE ASSOCIATION
[123 Any Avenue. City, State 12345
Third Party Administrator: YES Company
321 Knee Street, Suite 01, Some City, Some State 33333
(xxx) xxx-xxxx or (xxx) xxx-xxxx **Fax Enrollment/Change Form to: (xxx) xxx-xxxx**
Visit our website for more information at: www.westernhealth.com]

| | | | | |
|---|---|---|---|---|
| COMPANY NAME | | | GROUP NUMBER (office use) | |
| STREET ADDRESS (physical address only) | | | DIVISION NAME AND NUMBER (office use) | |
| CITY | STATE | ZIP | REQUESTED EFFECTIVE DATE | |
| BILLING/MAILING ADDRESS | | | COUNTY | FEDERAL EMPLOYER I.D. NUMBER |
| CITY | STATE | ZIP | TYPE OF INDUSTRY | |
| CHIEF EXECUTIVE OFFICER OR PROPRIETOR | | | YEARS IN BUSINESS | |
| BENEFITS ADMINISTRATOR / TITLE | | | PHONE | FAX |
| E-MAIL AND WEBSITE ADDRESS | | | OTHER LANGUAGE CONSIDERATIONS | |

DOES THE APPLICANT OFFER OTHER COVERAGE: ☐ YES ☐ NO
IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION

| | |
|---|---|
| 1. | 3. |
| 2. | 4. |
| PREVIOUS CARRIER(S)<br>1. | 2. |

Are all employees eligible for this plan covered by Worker's Compensation? ☐ YES ☐ NO

If NO, please explain: _____

Are your benefits subject to ERISA regulation? ☐ Yes ☐ No

**TYPE OF ORGANIZATION**:

☐ Sole Proprietorship ☐ Corporation ☐ Partnership Other_____

**ELIGIBLE EMPLOYEES:**

1. Total number of employees _____
2. Number of part-time, seasonal and temporary employees _____
3. Number of eligible employees (subtract line 2 from line 1) _____
4. Number of employees declining (complete waiver) or covered elsewhere _____
5. Total employees enrolling with ABC
   (subtract line 4 from line 3) _____

**CONTINUATION COVERAGE:**

Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: ☐ Federal COBRA

**BENEFITS:**

**[PPO Medical Plans**
☐ Option 15
☐ Option 20
☐ Option 30
☐ Option 40 ]

☐ Vision Rider

☐ Major/Minor Diagnostic Test Benefit Rider

| **RATES** (office use): | **MEDICAL** | **EMPLOYEE** | **EE + SP/1** | **EE + CH(REN)** | **EE + SP + CH(REN)** |
|---|---|---|---|---|---|
| [Option 15 | _____ | _____ | _____ | _____ | _____ |
| Option 20 | _____ | _____ | _____ | _____ | _____ |
| Option 30 | _____ | _____ | _____ | _____ | _____ |
| Option 40] | _____ | _____ | _____ | _____ | _____ |
| [Prescription Drug Benefit] | _____ | _____ | _____ | _____ | _____ |

EFFECTIVE/RENEWAL DATE _____ RAF: _____ OPEN ENROLLMENT: _____ TO:_____

# Enrollment / Premium Provisions

| GROUP NAME | GROUP NUMBER (office use) |
|---|---|

**SELECTED ELIGIBILITY REQUIREMENTS:** A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.

Eligible employees shall be active, full-time employees who usually work at least ___[30]_____ hours per week.

**CATEGORIES OF ELIGIBILITY:**

☐ **Dependents** [spouse, children]

☐ **Retired Beneficiaries** (subject to approval)

**COMMENCEMENT OF COVERAGE:**

☐ 1st month following Date of Hire

☐ 1st month following _____ days from Date of Hire

☐ Other (attach description)

**Note: All terminations are effective the last day of the month in which Employee ceases to be eligible under group eligibility provisions.**

**EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS:**

(Employer must contribute a minimum of [25%] of Employee only premium)

☐ **Employee Only $ _____ or _____ % of Rate**

☐ **Dependents $ _____ or _____ % of Rate**

**BROKER INFORMATION:**

☐ Existing Broker

☐ New Broker (must complete Agent Commission Agreement)

Broker Name: _____ Phone: _____

Agency: _____ Fax: _____

Broker Number: _____ E-mail: _____

Commission: ☐ Standard Scale ☐ Flat _____% ☐ Other: _____ License Number: _____

**COMMENTS:**

**EMPLOYER STATEMENT**

We wish to enroll our organization as an employer account with ABC Company.
We understand the eligibility rules applicable to enrollment and understand the premium requirements.
Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day of each calendar month. If premiums are not received from the employer, coverage for enrollees will be terminated on the last day of the month for which premium was received. Any other premium payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof. ABC Company reserves the right to terminate the Group Policy or the coverage of any individual Certificateholder who has made any material misrepresentation.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ _____

Signature Date

_____

Print Name and Title

**BROKER STATEMENT**

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona-fide business establishment; participation requirements have been met; that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

_____ _____

Broker Signature Date

**GTL APPROVAL**

_____

_____

Sales Approval Date Account Executive Date

ABC Company

# EMPLOYER NEW BUSINESS CHECKLIST

**T**

**The following documentation should be completed and submitted to YES Company by the 5th of the month:**

- ☐ Employer Group Application (to be completed by Employer)
- ☐ Enrollment forms _____ # of forms
- ☐ Copy of Rate Quote
- ☐ Employers must complete ABC Group Underwriting Questionnaire
- ☐ Waiver forms must be completed for eligible employees who refuse coverage for themselves *or* their dependents
- ☐ The selected ABC plan is primary to Medicare for *active* employees age 65 or older (and spouses age 65 or older of active employees).
- ☐ A copy of DE6 required
- ☐ A deposit in the amount of one month's premium

**Return Materials to: [YES Company**
**321 Knee Street**
**Suite 01**
**Some City, Some State 33333**
**(XXX) XXX-XXXX Phone**
**(XXX) XXX-XXXX Fax]**
**www.YEScompany.com]**

# ENROLLMENT APPLICATION & CHANGE FORM

[Product Logo]

Underwritten by: FIDELITY LIFE ASSOCIATION
[123 Any Avenue. City, State 12345
Third Party Administrator: YES Company
321 Knee Street, Suite 01, Some City, Some State 33333
(xxx) xxx-xxxx or (xxx) xxx-xxxx **Fax Enrollment/Change Form to: (xxx) xxx-xxxx**
Visit our website for more information at: www.westernhealth.com]

**Name of Employer** _____

**Group Number** _____ **Effective Date/Date of Change** _____

**PPO elected** _____

**Check Reason for Application**

- ❑ Address Change
- ❑ Special Enrollment
- ❑ Waiver of Insurance Election
- ❑ Open Enrollment
- ☐ New Subscriber
- ☐ Group Transfer
- ☐ COBRA
- ☐ Change Name
- ☐ Cancel
- ☐ Add a Family Member

Date _____

Cancellation Reason _____

Add a Family Member Reason _____

Terminate a Family Member Reason _____

Other Reason _____

## EMPLOYEE INFORMATION

| Last Name | Legal First Name | Nickname | Middle Initial | Status |
|---|---|---|---|---|
| | | | | ☐ Single ☐ Married |
| Home Address (Including mailing address if different) | | | | Date of Full-Time Employment |
| City | State | Zip | County | Classification |
| Home Telephone ( ) | Work Telephone ( ) | | | ☐ Out of Area<br>☐ Management |

## EMPLOYEE AND DEPENDENT(S) INFORMATION

| NAME (First, MI, Last)<br>(Social Security Number required for processing)<br>(child must be under age 25) | Date of Birth<br>MM/DD/YY | Relationship to Subscriber | Sex<br>M/F |
|---|---|---|---|
| 1. Employee Name<br>SSN# | / / | | |
| 2. Name of Spouse<br>SSN# | / / | | |
| 3. Dependent Name<br>SSN# | / / | ☐ Child ☐ Grandchild<br>☐ Stepchild ☐ Guardianship | |
| 4. Dependent Name<br>SSN# | / / | ☐ Child ☐ Grandchild<br>☐ Stepchild ☐ Guardianship | |
| 5. Dependent Name<br>SSN# | / / | ☐ Child ☐ Grandchild<br>☐ Stepchild ☐ Guardianship | |
| 6. Dependent Name<br>SSN# | / / | ☐ Child ☐ Grandchild<br>☐ Stepchild ☐ Guardianship | |

# ENROLLMENT APPLICATION & CHANGE FORM

## OTHER INSURANCE COVERAGE INFORMATION

1. Have you or your dependents had health insurance coverage with another carrier(s) at anytime during the last 12 months?

☐ Yes ☐ No If yes, answer the following:

****Provide information (below) about <u>all</u> the health insurance coverage you have had during the previous 12 months****

Name of Policyholder _____ SSN# of Policy holder _____

Effective date of policy ____/____/____ (month/day/year) Termination date of policy ____/____/____ (month/day/year)

Reason coverage ended: _____

Type of Plan: ☐ Group ☐ Individual ☐ Other Persons Covered: ☐ Self ☐ Spouse ☐ Child(ren)

Name of Insurance company _____ Telephone Number _____

Was this a group policy offered through an employer? ☐ Yes ☐ No If yes, provide the following:

Name of employer _____ Telephone Number _____

2. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this plan?

☐ Yes ☐ No If yes, answer the following:

Who will continue to be covered: ☐ Self ☐ Spouse ☐ Child(ren)

Effective date of the policy ____/____/____ (month/day/year) Type of Plan: ☐ Group ☐ Individual ☐ Other

Name of insurance company _____ Telephone Number (____) _____

Is this plan through your spouse's employer? ☐ Yes ☐ No If yes, provide the following:

Name of employer _____ Telephone number (____) _____

3. Do you or your dependents currently have Medicare coverage? ☐ Yes ☐ No If yes, answer the following:

Name of person covered by Medicare _____ Medicare claim number _____

Is Medicare eligibility due to? ☐ Over age 65 ☐ End-stage renal disease ☐ Total disability

Part A effective date ____/____/____ (month/day/year) Part B effective date ____/____/____ (month/day/year)

## DISCLOSURES, AUTHORIZATION AND SIGNATURE

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: the policy underwriters approve this application, eligibility requirements have been met, and a certificate of insurance is issued, which shall not be valid unless the first premium is paid. I further understand that this application will become a part of the policy and my certificate and any coverage afforded will be in consideration of the answers being true and complete and the premium paid. I also understand that any misstatement or failure to provide sought for information may be used as the basis for rescission of my insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Signature of Applicant** _____ **Date Signed** _____

| Underwriter completes | |
|---|---|
| Underwriter | Approved Date |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
| *Company Tracking Number:* | *(FID)(2/09)(LG-P)* | | |
| *TOI:* | *H16G Group Health - Major Medical* | *Sub-TOI:* | *H16G.002A Large Group Only - PPO* |
| *Product Name:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |
| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 09/01/2009 |

**Comments:**

**Attachment:**

Cert of Comp. with Rule 19 (FID)(2-09)(LG-P).pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Application | Approved-Closed | 09/01/2009 |

**Comments:**

See forms schedule tab

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Cover letter | Approved-Closed | 09/01/2009 |

**Comments:**

**Attachment:**

AR Large Group Policy 8-28-09.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Authorization Letter | Approved-Closed | 09/01/2009 |

**Comments:**

**Attachment:**

2-19-09 - Authorization Letter.pdf

**Certificate of Compliance with**
**Arkansas Rule and Regulation 19**

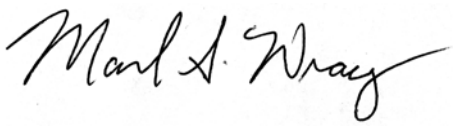
Insurer: Fidelity Life Association, a Legal Reserve Life Insurance Corporation

Form Number(s):

Group Major Medical Policy – (FID)(2/09)(LG-P)
Group Major Medical Expense Certificate – (FID)(2/09) (LG-C)
Group Major Medical Expense Schedule of Benefits – (FID)(2/09)(LG-S)AR
Amendatory Endorsement – (FID)(AEAR) (2/09)
Employer Application - (FID)(2/09)(LG-ER) AR
Employee Application - (FID)(2/09)(LG-EE) AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer



Mary Wray
Name

Secretary
Title

August 18, 2009
Date

INSURANCE
COMPLIANCE
CONSULTANTS, INC.

3925 East State Street, Suite 200
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 986-2355

August 18, 2009

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Fidelity Life Association NAIC #63290
FEIN #36-1068685
Large True Employer Plan
Group Major Medical Policy – (FID)(2/09)(LG-P)
Group Major Medical Expense Certificate – (FID)(2/09) (LG-C)
Group Major Medical Expense Schedule of Benefits – (FID)(2/09)(LG-S)AR
Amendatory Endorsement – (FID)(AEAR) (2/09)
Employer Application - (FID)(2/09)(LG-ER) AR
Employee Application - (FID)(2/09)(LG-EE) AR

Dear Commissioner Bowman:

We are hereby submitting the above referenced forms for review and approval in your state. These forms are new and are not intended to replace any forms previously approved in your state.

A Filing Letter of Authorization from Fidelity Life Association authorizing Insurance Compliance Consultants, Inc., to represent them in this filing and to work with the Department for the purposes of obtaining Departmental filing is enclosed.

Group Major Medical Policy, (FID)(2/09)(LG-P) will be issued to large employer groups in your state.

Group Major Medical Expense Certificate, (FID)(2/09)(LG-C) evidencing coverage under the Group Major Medical Policy. Amendatory Endorsement (FID)(AEAR)(2/09)will be attached to all Certificates issued in Arkansas. The Schedule of Benefits pages are attached to the Certificate based on the benefit levels selected by the employer.

Form (FID)(2/09)(LG-EE) AR is the employee enrollment application used to apply for coverage and form (FID)(2/09)(LG-ER) AR is the employer application.

The Policy document was prepared on a personal computer and will ultimately be printed from another data processing system that may cause some print style and/or page spacing changes. However, there will not be any changes to the actual text of the contract or to the general print size.

Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815) 986-2355, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

FIDELITYLIFE
Established 1896

Innovation Is Our Policy

Fidelity Life Association
1211 West 22nd Street, Suite 209
Oak Brook, IL 60523
Tel 630.522.0392
Fax 866-375-8175

February 19, 2009

Mr. Brian Camling
President
Insurance Compliance Consultants, Inc.
519 Colman Center Dr.
Rockford, IL 61108

Dear Mr. Camling:

Please accept this letter as written confirmation that Insurance Compliance Consultants, Inc. has authority to file the attached form(s) or a state specific variation of it, and to act on behalf of Fidelity Life Association regarding such filings, in all jurisdictions where this form(s) or a state specific variation of it is being filed. Fidelity Life Association may withdraw this authorization at any time, by giving notice to Insurance Compliance Consultants, Inc.

Sincerely,

Mark S. Wray

CFO, Sr. Vice President, Treasurer & Secretary

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ICCI-126261636* | *State:* | *Arkansas* |
| *Filing Company:* | *Fidelity Life Association, a Legal Reserve Life Insurance Company* | *State Tracking Number:* | *43256* |
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| *Project Name/Number:* | *Fidelity Life - Large Group (FID)(2/09)(LG-P)/Fidelity Life - Large Group (FID)(2/09)(LG-P)* | | |

# Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule | Schedule Item Name | Replacement Creation Date | Attached Document(s) |
|---|---|---|---|---|
| 08/18/2009 | Supporting Document | Cover letter | 08/28/2009 | AR Large Group Policy 8-18-09.pdf (Superceded) |
| 08/18/2009 | Form | Schedule of Benefits | 08/24/2009 | AR (FID)(2-09)(LG-S) AR Schedule of Benefits 3-30-09.pdf (Superceded) |
| 08/18/2009 | Form | Amendatory Endorsement | 08/24/2009 | (FID)(AEAR)(2-09).pdf (Superceded) |

INSURANCE
COMPLIANCE
CONSULTANTS, INC.

3925 East State Street, Suite 200
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 986-2355

August 18, 2009

Honorable Julie Benafield Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Fidelity Life Association NAIC #63290
FEIN #36-1068685
Large True Employer Plan
Group Major Medical Policy – (FID)(2/09)(LG-P)
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Employee Application - (FID)(2/09)(LG-EE) AR

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Your prompt review of this submission will be greatly appreciated. If I can provide any additional information, please contact me at (815)316-6714, fax me at (815) 986-2355, or e-mail me at Brendadawson@inscompliance.com . Thank you.

Sincerely,

Brenda Dawson

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

# SCHEDULE OF BENEFITS / *[Options are in Brackets]*

**Policyholder:**
**Employer:**
**Insured:**
**Certificate Number:**
**Effective Date:**
**Premium Due Date: [1st of the month]**
**Schedule Date:**
**Dependent Spouse:**
**Dependent Child(ren):**
**Dependent Limiting Age: up to age 19**
**Student Eligibility Limiting Age: up to age 23**
**Pre-Existing Conditions Limitations Apply: [Yes/No]**
**Year: [Calendar] [Plan] Year**

## Medical Expense Benefits

| | |
|---|---|
| **Lifetime Maximum Benefit** | [A combined lifetime maximum benefit of ][$1,000,000 – $5,000,000] |

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person Year:** | **Out-of-Network Cost to Covered Person [Calendar] [Plan]** |
|---|---|---|
| **Deductible per Year [(1)]** | | |
| Individual | [$250 - $10,000] | [2x In-Network] [$500 - $20,000] |
| Family [2x Individual] | [2x individual] [$500 - $20,000] | [2x In-Network] [$1,000 - $40,000] |
| **Coinsurance for all Eligible Expenses** | [0% - 50%] | [0% - 50%] |
| **Out-of-pocket Maximum (OOP)[(2)(3)]** | | |
| Individual | [$500 - $10,000] | [2x In-Network] [$1,000 - $20,000] |
| Family [2x Individual] | [2x individual] [$1,000 - $20,000] | [2x In-Network] [$2,000 - $40,000] |
| Deductible Applies | [Yes, No] | |
| Coinsurance Applies | [Yes, No] | |
| Copayment Applies | [Yes, No] | |
| Out-of-Network Deductible & OOP apply to In-Network Deductible & OOP | [Yes, No] | |
| Out-of-Network Maximum per year: | [Not Applicable] | [Not Applicable, $500,000, $5,000,000] |
| **Physician Care** | | |
| • [Office Visit] | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • [Specialist Office Visit] | [Co-payment [$0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Lab Tests & X-rays [Major] [Minor] | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Office Surgery | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |

# SCHEDULE OF BENEFITS / ***[Options are in Brackets]***

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| • Allergy Injections | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Urgent Care | [Co-payment [($0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| **Preventive Care**<br>• Physician Services<br>• History<br>• Physical Examinations<br>• Laboratory Test, X-rays, Blood Pressure checks and other services for the early detection of diseases when ordered by a Physician<br>• Annual cervical/pap smear<br>• Prostate cancer screening | [Co-payment [($0 - $100)] [*] | [deductible/coinsurance] |
| Maximum Benefit per Year: | [Not Applicable] [Limited to a Calendar Year maximum of [$50 - $2,500]] | |
| **Pregnancy/Maternity Care**<br>• [Office visits (pre & postnatal)<br>• [Hospitalization] | [Co-payment [($0-$100)]][*] [deductible/coinsurance] | [deductible/coinsurance] |
| **[Vision Exam – Routine]** | [Co-payment [($0-$100)]][*] [(Limited to Calendar Year maximum benefit of [$50 - $1,000])] [(Limited to max per Year benefit of [1] visits)] | [deductible/coinsurance] [Not Covered] |
| **[Hearing Exam – Routine]** | [Co-payment [($0-$100)]][*] [(Limited to Calendar Year maximum benefit of [$50 - $1,000])] [(Limited to max per Year benefit of [1] visits)] | [deductible/coinsurance] |
| **Hospitalization Inpatient Services (4)** | | |
| • Semi-private Hospital Room & Board | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Physician & Surgeon Services | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Lab, X-ray and other facility charges | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| • Inpatient Rehabilitation | [Co-payment [($10 - $100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |
| **Hospital Outpatient Surgery (4)** | [deductible/coinsurance] | [deductible/coinsurance] |
| **Outpatient Services** | [Co-payment [$0-$100]] [*] [deductible/coinsurance] | [deductible/coinsurance] |

# SCHEDULE OF BENEFITS / ***[Options are in Brackets]***

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| **Emergency Services** | | |
| • [Office Visits] | [[Co-payment [($50 - $1,000]] [deductible/ coinsurance] | [[Co-payment [($50 - $1,000]] [deductible/ coinsurance] |
| • Emergency Room ([Co-payment] waived if admitted) | [[Co-payment [($50 - $1,000)]] [deductible/ coinsurance] | [[Co-payment [($50 - $1,000)]] [deductible/ coinsurance] |
| **[Ambulance** | | |
| • Ground | [deductible/coinsurance] | [deductible/coinsurance] |
| • Air] | [Maximum benefit $50 - $10,000] [deductible/coinsurance] [Maximum benefit $0 - $25,000] | [deductible/coinsurance] |
| **Chemical Dependency [(4)]** | | |
| • Inpatient treatment of alcohol and drug dependency | [deductible/coinsurance] (Limited to $3,000 in any 2 month period, $6,000 for each 24-month period) and limited to $12,000 per covered person per lifetime [(Limited to Calendar Year maximum benefit of [10-100 visits)] | [deductible/coinsurance] |
| **Mental or Nervous Disorders** | | |
| • Inpatient | [[Co-payment [($0 - $100)]] [deductible/coinsurance] | [deductible/coinsurance] |
| • Outpatient | [deductible/coinsurance] [(Limited to Year maximum benefit of [10-100 visits)] [Co-payment [($0-$100)]][*] | [deductible/coinsurance] |
| **Rehabilitation Services** | | |
| • Inpatient [(4)] | [deductible/coinsurance] [Co-payment [($0-$250)]][*] [(Limited to Calendar Year maximum benefit of [30 – 60 visits] | [deductible/coinsurance] |
| • Outpatient | [deductible/coinsurance] [Co-payment [($0-$100)]][*] [(Limited to Calendar Year maximum benefit of [50 – 75 visits] | [deductible/coinsurance] |
| **Durable Medical Equipment [(4)]** | [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [$2,500 – $10,000)] [Rental limited to purchase price] | [deductible/coinsurance] |
| **Skilled Nursing Facility [(4)]** | [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [30 – 270 days)] | [deductible/coinsurance] |

| **Covered Services per [Calendar] [Plan] Year** | **In-Network Cost to Covered Person** | **Out-of-Network Cost to Covered Person** |
|---|---|---|
| **Home Health Care [(4)]** | [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of [30 – 180 visits)] | [deductible/coinsurance] |

| | |
|---|---|
| **Hospice Service [(4)]** | [deductible/coinsurance] [deductible/coinsurance] [(Limited to Calendar Year maximum benefit of $500 - $10,000, Not Applicable)] |
| **Organ Transplant (4)** | [Co-payment [($10 - $100]] [deductible/copayment] [deductible/copayment] |
| **Manipulative Services** | [Co-payment ($0 - $100] [*] [No coverage] [deductible/coinsurance] [deductible/coinsurance] [Limited to Calendar Year maximum benefit of [$500 - $5,000])] |
| **Acupressure/Acupuncture** | [(Limited to max per Year benefit of [10 - 40 visits)] [Co-payment ($0 - $100] [*] [No coverage] [No coverage] [deductible/coinsurance] [deductible/coinsurance] [Limited to Calendar Year maximum benefit of [$500 - $5,000])] |
| **Temporomandibular Joint Dysfunction (TMJ)** | [(Limited to max per Year benefit of [10 - 40 visits)] [Co-payment ($0 - $100] [*] [Co-payment ($0 - $100] [deductible/coinsurance] [deductible/coinsurance] |
| **Infertility** | [Co-payment ($0 - $250] [*] [Co-payment ($0 - $250] [deductible/coinsurance] [deductible/coinsurance] (Limited to a lifetime maximum benefit of $15,000-$25,000])] |
| **Injectible & Specialty Medications** | [No coverage] [No coverage] [deductible/coinsurance] [deductible/coinsurance] |
| **[Prescription Drug** | |
| Rx Deductible | [deductible & coinsurance] [Not Covered] [Does not apply to medical deductible & out-of-pocket maximum] |
| Prescription Contraceptive Coverage | [$0 - $200] [Not Applicable] [Covered, Not Covered] |
| • **Retail and Mail Order – 34 day supply** | [Co-payment] |
| - Generic | [($5 - $50)] |
| - Brand Preferred | [($20 - $75)] |
| - Brand Non-Preferred | [($20 - $100)] |
| | [Refer to the Outpatient Prescription Drug Benefit in the Certificate for coverages and exclusions to prescription coverage.] |

**[* Benefits marked with an asterisk (*) are not subject to the Calendar Year Deductible.]**

[(1) Copays do not count toward the Calendar Year deductible.]

[(2) [Deductible does [not] apply to OOP maximum.]

[(3) [Co-pay does [not] apply to OOP maximum.]

[(4) Requires Pre-Authorization. There is a penalty of [$250] for failure to obtain Pre-Authorization, but in no event will the penalty exceed 50% of the total charges. Penalty payments do not apply toward a deductible or out-of-pocket maximum amounts.

# SCHEDULE OF BENEFITS / ***[Options are in Brackets]***

[The following are subject to Pre-Authorization prior to obtaining services:

Alcohol or Chemical Dependency treatment
Cardiac and Pulmonary Rehabilitation
Durable medical Equipment, Orthotics, Prosthetics
Elective Surgery
Mental Illness treatment
Occupational Therapy
Organ Transplant
Outpatient Angiographic Procedures
Outpatient MRI
Outpatient Nuclear Imaging]
Home Health Care
Hospice Care
Inpatient admissions
Inpatient Rehabilitation
Outpatient Surgery
Physical Therapy
Same Day Surgery
Skilled Nursing Care
Speech Therapy

# FIDELITY LIFE ASSOCIATION, **a Legal Reserve Life Insurance Company**
**Oak Brook, Illinois**

## ARKANSAS AMENDATORY ENDORSEMENT

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance to which this amendatory endorsement is attached are amended as follows:

**A. PART 2 – ELIGIBILITY FOR INSURANCE**, the following changes are hereby made:

1. **DEPENDENT ENROLLMENT ELIGIBILITY**, item 2. is deleted and replaced with the following:

   2. You may enroll any new Dependent who first meets the definition of Dependent, after Your Enrollment Date, by completing and submitting an Enrollment Form to Us through Your Employer. Your Enrollment Form must be submitted to Us within 31 days after the date on which Your Dependent first meets the criteria for a Dependent.

      a. If Your new Dependent is a newborn Child, coverage will be provided from the moment of birth and will remain in force for 90 days. To continue coverage for Your newborn Child, You must submit an Enrollment Form for Your newborn Child and pay the required premium.

      b. If Your new Dependent is an adopted Child, a Child placed in Your home for adoption, or a minor under Your charge, care, and control for whom You have filed a petition to adopt, prior to the Child's 18th birthday, coverage will be provided from the date of adoption or the date of placement for adoption until 60 days after the date of adoption or date of the date of placement for adoption. To continue coverage of an adopted Child or Child placed for adoption, You must submit an Enrollment Form for Your adopted Child or Child placed for adoption and pay the required premium.

2. **EMPLOYEE AND DEPENDENT ENROLLMENT PERIODS (NOT APPLICABLE TO LATE ENROLLES) ELIGIBILITY**, items 1. B and C are deleted and replaced with the following:

   B. If Your Dependent is a newborn Child, who is born after the Initial Enrollment Period, You must notify Us in writing within 90 days after the newborn Child's birth and any additional premium for the Child that is necessary to continue coverage beyond the initial 90 day period must be paid. In addition to Your newborn Child, You may enroll Your eligible spouse at the time You enroll Your newborn Child.

   C. If Your Dependent is an adopted Child or Child placed for adoption, and the adoption or placement for adoption begins after the Initial Enrollment Period, You must notify Us in writing within 60 days after the date of adoption or date of placement for adoption and any additional premium for the Child that is necessary to continue coverage beyond the initial 60 day period must be paid. In addition to Your adopted Child or Child placed for adoption, You may enroll Your eligible spouse at the time You enroll Your adopted Child or Child placed for adoption.

**B. PART 6 – COVERED CHARGES** the following changes are hereby made:

1. Item **3. PHYSICIANS OFFICE SERVICES**, the following is added:

   We will not refuse to reimburse a Physician at the full rate for health care services provided by a Physician assistant if the practice complies with the laws of Arkansas. We will not impose a practice or supervision restriction of a Physician assistant that is inconsistent with or more restrictive than the restriction already imposed by the laws of Arkansas.

2. Item **16. DIABETIC SELF-MANAGEMENT TRAINING**, is deleted and replaced with the following:

   Benefits are payable for services and supplies to enable a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent Hospital care and complications. Covered Charges include services provided by a Physician or medical professional designated by the Physician. Visits for diabetic training, including medical nutrition education, are covered as follows:

   a. one (1) lifetime training program per Insured Person for diabetes self-management training when Medically Necessary as determined by a Physician and when provided by an appropriately licensed

health care professional upon certification by the health care professional providing the training that the Insured Person has successfully completed the training;

b. additional diabetes self-management training in the event that a Physician prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the Insured Person's symptoms or conditions; and

c. diabetes self-management training shall be provided only upon prescription by a licensed Physician.

3. Item **17. PREGNANCY/MATERNITY**, the last paragraph pertaining to well newborn nursery care is deleted and replaced with the following:

   If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

4. Item **20. CHEMICAL DEPENDENCY**, is deleted and replaced with the following:

   Benefits are payable for the treatment of chemical dependency in an alcohol or drug dependency treatment facility or in a Hospital as shown in the Schedule of Benefits.

   For the purposes of this benefit the following definitions apply:

   Alcohol or drug dependency treatment facility means a public or private facility, or unit in a facility, that is engaged in providing treatment 24-hours a day for alcohol or drug dependency or substance abuse, that provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a Physician, and that is also properly licensed or accredited to provide those services by the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health.

   Alcohol or drug dependency means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and that may, but need not, include a pattern of tolerance and withdrawal.

5. Item **22. DENTAL ANESTHESIA**, is deleted and replaced with the following:

   Benefits are payable for dental anesthesia and Hospital charges for dental procedures in a Hospital or Ambulatory Surgical Center in order to safely and effectively perform dental procedures when the Insured Person is:

   A. a child under 7 years of age, and determined by two dentists to have a significantly complex dental condition;
   B. diagnosed with a serious medical or physical condition; or
   C. has a significant behavioral problem as determined by his or her Physician.

6. Item **23. AMBULANCE SERVICES**, the following is added:

   If an Insured Person files a claim for covered professional ambulance services, direct reimbursement will be made to the provider of the services if the provider has not received payment for those services from any other source.

7. Item **31. INFERTILTY**, the following is added:

   Benefits are payable for in vitro-fertilization procedures when:
   A. the patient is an Employee or Dependent spouse covered under the Policy;
   B. the patient’s occytes are fertilized with the sperm of the patient’s spouse;
   C. the patient and the patient’s spouse have a history of unexplained infertility of at least 2-years duration; or the infertility is associated with one or more of the following medical conditions:
      1) endometriosis;
      2) exposure in utero to diethylstilbestrol, commonly known as DES;
      3) blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
      4) abnormal male factors contributing to the infertility; and
   D. the in vitro-fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists guidelines for in vitro-fertilization clinics, or those

performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro-fertilization; or

E. the patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

Cryopreservation is included as an in vitro-fertilization procedure.

8. Item **32. PREVENTIVE CARE**, is deleted and replaced with the following:

Benefits are payable for preventive services for an Insured Person, not to exceed the limits specified in the Schedule of Benefits consisting of:

A. Physician services;
B. History;
C. Physical Examination;
D. Laboratory Test, X-rays, Blood Pressure checks and other services for the early detection of diseases when ordered by a Physician;
E. Annual cervical pap smear;
F. Prostate Cancer Screening
   Benefits are payable for an annual medically recognized diagnostic examination for the detection of prostate cancer.
   Coverage includes:
   1) a physical examination for the detection of prostate cancer; and
   2) a prostate-specific antigen test used for the detection of prostate cancer for each male who:
      a. is at least 50 years of age and is asymptomatic; or
      b. is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor.

9. Item **33. PRESCRIPTION DRUGS AND MEDICINES**, Dispensing Limitation, sub-item B. pertaining to prescription mail orders is deleted in its entirety.

10. Item **33. PRESCRIPTION DRUGS AND MEDICINES**, the following is added:

We will not limit or exclude coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided:

A. The drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one (1) or more such compendia:
   1) The American Hospital Formulary Service drug information;
   2) The United States Pharmacopoeia dispensing information; or
B. The drug has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

   Coverage of such drug includes Medically Necessary services associated with the administration of the drug.

   We will not contract with a pharmacist, pharmacy, pharmacy distributor, or wholesale drug distributor, nonresident or otherwise, to provide benefits for the shipment or delivery of a dispensed legend drug into the State of Arkansas, unless the pharmacist, pharmacy, or distributor has been granted a license or permit from the Arkansas State Board of Pharmacy to operate in the State of Arkansas.

We shall apply the same coinsurance, Copay, and Deductible factors to covered drug prescriptions filled by a pharmacy provider who participates in Our network if the provider meets Our explicit product cost determination. We will not set a limit on the quantity of drugs which an Insured Person may obtain at any one (1) time with a prescription, unless the limit is applied uniformly to all pharmacy providers in Our network.

11. The following items are added:

**34. PREVENTIVE AND PRIMARY CARE SERVICES FROM BIRTH TO 18 YEARS OF AGE**

Benefits are payable for the following child preventive care services including:

1. Newborn screening tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants as mandated by law;
2. Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time;
3. Children's preventive health care services are provided for covered Dependents for periodic preventive care visits from the moment of birth through 18 years of age. Coverage includes 20 visits under the supervision of a single Physician during the course of one visit, and at the following intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.
4. Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

Recommended immunization services are exempt from any Copay, coinsurance, Deductible and dollar limit provisions.

For purposes of this benefit, the following definitions apply:

Children's preventive health care services means Physician-delivered or Physician-supervised services for eligible Dependents from birth through 18 years of age, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

Periodic preventive care visits mean the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

**35. CANCER SCREENING TESTS**

Benefits are payable for the following cancer screening tests:

A. Mammography
   1) a baseline mammogram for a female Insured Person 35 to 40 years of age;
   2) a mammogram for a female Insured Person 40 to 49 years of age every one to two years based on the recommendation of the woman's physician;
   3) a mammogram each year for a female Insured Person who is at least 50 years of age;
   4) upon the recommendation of a female Insured Person's Physician, without regard to age, when the female Insured Person has had a prior history of breast cancer or when the female Insured Person's mother or sister has had a history of breast cancer; and
   5) diagnostic mammograms as recommended by the Insured Person's physician.

B. Colorectal Cancer Screening – Examinations and laboratory tests as prescribed by a Physician for:
   1. Insured Person's who are 50 years of age or older;
   2. Insured Person's who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines; and
   3. Insured Person's experiencing the following symptoms of colorectal cancer as determined by a Physician: (a) bleeding from the rectum or blood in the stool; or (b) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than 5 days.

   An examination of the entire colon, including:
   1. The following examinations or laboratory tests, or both:
      (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years;
      (ii) A double-contrast barium enema every five (5) years; or
      (iii) A colonoscopy every ten (10) years; and
   2. Any additional medically recognized screening tests for colorectal cancer required by the Director of the Division of Health of the Department of Health and Human Services, determined in consultation with appropriate health care organizations.

The Insured Person shall determine the choice of screening strategies in consultation with a health care provider.

Screenings shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

1. If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
2. For individuals with one or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
3. If single tubular adenoma of less than one centimeter (1 cm) is found, follow-up is recommended in five (5) years; and
4. For Insured Persons with large sessile adenomas greater than three (3) centimeters (3 cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

**36. MEDICAL FOOD OR LOW PROTEIN FOOD PRODUCT**, the following is added:

Benefits are payable for Medical Food or Low Protein Modified Food Products for the treatment of an Insured Person inflicted with phenylketonuria (PKU), galactosemia, organic acidemias, and disorders of amino acid metabolism if: (a) the medical food or low protein modified food products are prescribed as Medically Necessary for such treatment; and (b) the products are administered under the direction of a Physician.

For the purposes of this benefit, the following definitions apply:

Low Protein Modified Food Product means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

**37. TREATMENT OF THE BONES AND JOINT OF THE FACE, HEAD AND NECK**, the following is added:

Benefits are payable for treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Covered Charges include both surgical and nonsurgical procedures. Coverage will be provided for Medically Necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Coverage shall be the same as that provided for any other musculoskeletal disorder in the body.

**38. SPEECH AND HEARING SERVICES**, the following is added:

Benefits are payable for care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification.

C. **PART 7 – EXCLUSIONS AND LIMITATIONS,** the following changes are hereby made:

1. Item #30 pertaining to Mental or Nervous Disorders is deleted in its entirety.

2. Item #40 pertaining to Serious Mental Illness is deleted in its entirety.

3. Item #43 pertaining to Temporomandibular Joint Dysfunction is deleted in its entirety.

D. **PART 10 – RENEWABILITY AND TERMINATION,** the following are hereby added:

**Continuation of Coverage**

1. Any Insured Person whose coverage would otherwise terminate due to termination of employment or a change in marital status may continue coverage under the Policy for themselves and their eligible Dependents.

2. Continuation of coverage shall be available only to Employees who have been insured continuously under the Policy during the 3-month period prior to the termination of employment or change in marital status.

3. Continuation of coverage shall not be available to an Insured Person who is eligible for:
   A. Federal Medicare coverage; or
   B. Full coverage under any other group accident and health policy or contract.
      1) The other coverage must provide benefits for all preexisting conditions to be considered full coverage.
      2) Accordingly, an Insured Person may continue coverage under the Policy until all Pre-Existing Conditions are covered or would be covered under another group policy or contract or until termination pursuant to paragraph 6 below or pursuant to the applicable provisions of federal law.

4. An Insured Person who wishes to continue coverage must request continuation in writing not later than 10-days after the termination of employment or the change in marital status.

5. An Insured Person who requests continuation of coverage must pay the premium required on a monthly basis and in advance.

6. Continuation of coverage will end upon the earliest of the following dates:
   A. 120-days after continuation of coverage began;
   B. The end of the period for which the Insured Person made a timely contribution;
   C. The contribution due date following the date the Insured Person becomes eligible for Medicare; or
   D. 1) The date on which the Policy is terminated.
      2) However, if the Policy is replaced by Us, continuation shall continue under the new coverage.

7. At the termination of the continued coverage, an Insured Person will be offered a conversion policy (see the Conversion section below).

8. Insured Person's choosing to utilize the Conversion privilege below may do so and thereby waive their right to continuation of coverage under this section.

**Conversion**

1. An Insured Person whose insurance under the Policy has been terminated for any reason, including the discontinuance of the Policy in its entirety, shall be entitled to have issued to him or her by Us a policy of accident and health insurance referred to in this section as a "conversion policy".

2. An Insured Person shall not be entitled to a conversion policy, if the termination of the coverage under the coverage was a result of his or her failure to pay any required contribution or if the coverage under the Policy is replaced by similar coverage within 31-days. An Insured Person wishing to exercise his or her conversion privilege must apply for the conversion policy in writing not later than 30-days after the termination of coverage under the Policy.

3. The conversion policy shall provide coverage equal to or greater than the minimum standards established by the Insurance Commissioner.

4. We shall not offer the conversion policy to any Insured Person who is eligible for:

   A. Medicare coverage; or
   B. Full coverage under any other group accident and health policy or contract. This other coverage must provide benefits for all preexisting conditions to be considered full coverage.

   Accordingly, an Insured Person may convert to a conversion policy and remain covered by that policy until all Pre-Existing conditions are covered or would be covered under another group policy or contract.

5. The initial premium for the conversion policy for the first 12-months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to individually underwritten standard risks for the

age and class of risk of each person to be covered under the conversion policy and for the type and amount of insurance provided

**E. PART 11 – GENERAL PROVISIONS,** the following change is hereby made:

1. **Time Payment of Claims – Clean Claim** is added:

   We will pay, deny or settle all benefits due for clean claims within 30 calendar days after receipt of proof of loss submitted electronically or within 45 days by any other method.

   If the resolution of a claim requires additional information, We will, within 30 calendar days after receipt of the claim, give the Employee a full explanation of what additional information is needed. If the Employee and the Provider have provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within 30 calendar days after receipt.

   If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

   For the purpose of this provision, the following definition has been added:

   "Clean Claim" means a claim that is submitted on a HCFA 1500 or on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on the Plan's standard claim form with all required fields completed in accordance with the Plan's published claim filing requirements. A Clean Claim does not include a claim (1) for payment of expenses incurred during a period of time for which premiums are delinquent, or (2) for which the Plan needs additional information in order to resolve one or more outstanding issues.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

**FIDELITY LIFE ASSOCIATION, a Legal Reserve Life Insurance Company**

[ ][ ]

**SECRETARY** **PRESIDENT**